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TOWARD MENTAL HEALTH IN SCHOOL

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PREFACE

THIS small book is not intended as a substitute for, or even an addition to, the large number of books now available which attempt to deal in a comprehensive fashion with the mental health of the child in school. It is intended, rather, as an introduction to a rich field of study which, for many teachers, is still largely strange and unfamiliar territory.

Accordingly, there are two quite definite, if somewhat limited, objectives in the following presentation. The first of these is to provide, in simple non-technical terms, the minimum of *factual information about mental disease* which is essential to the development of a healthy attitude toward the subject and which, therefore, is a necessary preliminary to any constructive efforts directed toward better mental health in school. The second objective is to discuss certain of the *mental health difficulties of normal children* in an effort to illustrate an approach to such problems by which teachers can make a significant contribution to the maintenance of good mental health in school.

The writer is indebted, not only to the authors whose books he recommends for study (pp. 150-1), and to his colleagues for their helpful criticism, but

perhaps most of all, to those groups of experienced teachers whom he has been privileged to "teach" and whose practical viewpoint and theory-puncturing questions have done much to determine the form of this brief introduction to mental hygiene.

C. R. M.

Toronto,
July, 1939.

I

INTRODUCTION

THERE may have been a time when it was necessary to defend the view that teachers should be concerned about the health, as well as the education, of their pupils. If so, that time has now passed. Today, teachers themselves are demanding that they be provided with whatever information is available on health matters. They seem to consider that, in order to be *good teachers*, they need to be, not only interested in, but adequately informed about, child health.

This recognition that the health of the child in school is a matter of direct educational significance is not due wholly to the fact that teachers have found the sick child impossible to teach. It is due, even more, to an increasing recognition that there are broader and more important objectives in teaching than the inculcation of a narrow set of academic skills. The modern teacher no longer conceives of education as a routine matter of turning out human adding machines, automatic readers, and mechanical spellers. It has gradually dawned on the community at large, and on the teaching profession in particular, that the supreme function of the school is not so much to "train minds" as it is to develop healthy, efficient, useful people. It has become evident that it is a futile waste of time and effort to spend years "training

minds" if those minds are simply going to break down because they belong to people who are in such poor health that they can make no use of the skills which they have been taught.

In recognizing that an education is of no value to a person whose poor health renders him incapable of using it, the modern school is faced with a direct and immediate responsibility. Since both our methods of teaching and the circumstances under which we teach directly affect the health of our pupils for good or for ill, we must see to it that these methods and these circumstances are favourable. This is not someone else's task. It is the inescapable responsibility of the modern school and the modern teacher.

With respect to the physical health of the child in school, much progress has already been made. Care is now taken in most schools to see that classrooms are properly lighted and adequately ventilated, that lavatory facilities are kept in a sanitary condition, that drinking water is pure, and that there is sufficient in the way of medical supervision to prevent the spread of communicable illnesses and preserve a fairly high standard of physical health in the school population. Even more significant, perhaps, is the contribution which the school has made in the field of public health education. Children in school have been encouraged to develop those relatively simple but

fundamental habits upon which good physical health is known to be based. They, in turn, have carried this information back into their homes and, in this way, the practice of physical hygiene in the entire community has been materially improved.

Thus, in the last twenty years, teachers have made a tremendous contribution in the field of physical health,—both directly, in helping to protect child health at school, and indirectly, in helping to spread accurate health information throughout the community. There is every reason to believe that, in the next twenty years, teachers can and will make an equally significant contribution in the field of mental health. Such contribution will doubtless be along the same lines: directly, by making sure that what they teach, and the way in which they teach it, are conducive to good mental and emotional health; indirectly, by helping to spread accurate and precise information concerning those important habits upon which good mental health is known to be based.

Unfortunately, the whole subject of mental health and mental disease is, for many people, still shrouded in the mists of fear and superstition. This is only partly due to the relatively slower progress of scientific investigation in this field. Careful study of those who have become mentally ill has yielded important and useful information.

While there is much that is still unknown about certain types of mental disease, enough has already been learned to indicate that many mental illnesses are unnecessary and could be prevented if more adequate use were made of our existing knowledge. The actual practice of mental hygiene in the community lags far behind the present status of scientific information. Well-informed teachers can probably do more than anyone else to correct this lag.

No one would deny that teachers need special training in order to become skilful at the task of developing efficient habits of reading in their pupils. It is equally true that teachers need special training in order to become skilful at the task of developing healthy habits of emotional control in their pupils. While it is admittedly important that a child should be able to read, it may be even more important, on occasion, that a child should be able to hold his temper.

The time has passed when we are satisfied to depend entirely on our "natural talent" or "common sense" in dealing with children. In matters of physical health, we no longer suppose that teachers (or even mothers) know "by instinct" what is best for the health of children,—that they can tell "intuitively" what diet will build strong bodies or what precautions are necessary to preserve healthy teeth. These are matters with respect

to which we now demand accurate and reliable scientific information. Similarly, with respect to mental and emotional health, teachers (and parents) are demanding more adequate and more precise information concerning factors which help or hinder the development of good mental health in children.

II

FACING FACTS

THERE are certain habits which are favourable to the maintenance of good mental health. One of the most important of these is the habit of *facing facts*. Lest this be thought too vague and indefinite a notion, it may be well to illustrate at this point just what is meant by "facing facts." Accordingly, it is proposed that we commence practising this habit immediately by facing the fact of mental disease as it exists in our community.

Mental disease is a fact which many of us prefer to ignore. When we hear of someone who has "gone insane," we are apt to regard it as a fearful and mysterious tragedy about which the less said, the better. We no longer feel this way about tuberculosis or even about cancer. The time is coming when we shall no longer feel this way about mental disease.

The fact is that some knowledge of disease is necessary for intelligent action in preserving health. It is only when we have some understanding of the causal factors responsible for an illness that we are in a position to do anything about preventing it. Certainly, whatever is known about how to preserve good mental health has been learned from a careful study of people who have become mentally ill.

Obviously, there is no more need for teachers to become psychiatrists or specialists in mental disease than there is need for them to become physicians. Yet they do need to know something about both physical diseases and mental diseases if they are to give intelligent help in the preservation of good all-round health in their pupils.

What, then, are the facts about mental disease? How common is mental disease? How frequently does it occur among the people in our community? Is it becoming any more frequent than it used to be? What does it cost the community? What *is* mental disease? What causes it? What can be done about it when it has occurred? What can be done about preventing its occurrence?

The Frequency of Mental Disease

How prevalent is mental disease? Many people are inclined to feel that severe mental illnesses must be rather infrequent because they seldom hear much about them. Yet the facts fail to support any such conclusion.

In the mental hospitals of the Province of Ontario, there are more than fourteen thousand patients suffering from acute or chronic forms of severe mental illness. What does this fact mean? It means, for example, that there are as many patients in the *mental* hospitals of this Province as there are patients in *all* other types of hospitals

combined (general hospitals, tuberculosis sanatoria, Red Cross Hospitals, Hospitals for Incurables, etc.)[1]

This is, of course, not peculiar to Ontario. A similar situation is found in most modern civilized communities. At any given time, there are as many people receiving hospital treatment because of severe mental illness as there are people receiving hospital treatment because of severe physical illness. Thus, it is evident that mental disease occurs in our community with a frequency which we cannot afford to ignore.

Statisticians have calculated that approximately one in every twenty persons born in a community such as ours will, at some time during his life, have to enter a mental hospital because of severe mental illness.

The very serious prevalence of mental disease in our community is a fact to be faced squarely and calmly. No good purpose is served by becoming alarmed about it. Not infrequently, one encounters sensational statements to the effect that mental disease is increasing in frequency at such a rate that, unless some drastic action is taken, the "insane" will eventually outnumber the "sane." What are the facts? Are such alarming predictions justified by the available evidence?

[1]Actual figures for Ontario: Total number of patients in residence as on September 30, 1938: Mental hospitals, 14,086; all other hospitals, 13,865.

Is Mental Disease Increasing?

There is no valid evidence that mental disease is becoming any more frequent than it has always been.[2]

It is a fact that there are many more people in mental hospitals today than there were years ago. It is also true that this increase in mental hospital population is much larger than any corresponding increase in the general population. Yet these facts do not indicate that there has been any actual increase in the prevalence of mental disease.

There are many factors which have contributed to an increase in the number of patients cared for in mental hospitals. Higher standards of humane care and greatly improved treatment facilities have led to increased public confidence and greater readiness to have persons who are mentally ill admitted to hospital for suitable treatment. Improved diagnostic methods mean that large numbers of the mentally ill who would, in former times, have been thrown into prison or allowed to wander at large are now identified as mentally ill and given proper treatment in hospital. Private home care has become too costly for many families in recent years and these patients have been admitted

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[2]For an excellent summary of the detailed evidence upon which this conclusion is based, see C. Landis and J. D. Page, *Modern Society and Mental Disease* (Farrar and Rinehart, 1938), 137-50.

to hospital. These and many other factors have contributed to a greatly increased mental hospital population. This increase primarily reflects greater demand for, and greater utilization of, hospital facilities rather than any *actual* increase in the frequency of mental disease.[3]

The fact is, of course, that mental disease does not need to be increasing in order to warrant serious consideration. It is already frequent enough to justify more widespread understanding of its nature, origin, and possible prevention.

Cost of Mental Disease

What does mental disease cost our community? In 1938, the cost of maintaining the twelve mental hospitals operated by the Province of Ontario amounted to more than four million dollars. This very considerable expense does not include the capital cost of buying property and constructing the new hospital buildings which are constantly required, nor does it give any indication of the enormous economic cost represented by the lost earning power of those who have become incapacitated by reason of mental illness.[4]

[3]There is evidence of a slight actual increase in the frequency of certain mental diseases associated with old age. This is a natural result of an increase in the average life span which means that larger numbers of people are living long enough to develop these particular diseases.

[4]Estimated economic loss to the United States on account of mental disease *for the year 1931:* $742,145,956.00 (H. M. Pollock, in *Mental Hygiene*, 1932, XVI, 289-99).

The cost of mental disease in terms of human suffering and unhappiness needs no emphasis. Yet even from a purely economic point of view, mental disease constitutes a problem of major importance. The community has a right to expect that we, as teachers, make sure that we are taking whatever precautions we can against the unnecessary development of mental disease.

Poor Mental Health in Pupils

The prevalence and cost of mental disease are facts which must be faced squarely by anyone who, as a citizen, is interested in the welfare of his community. For teachers, there are certain further facts which must be faced without evasion. The first of these has to do with our pupils.

In the average class of about forty children, there are at least *ten* children whose mental health is so poor as to interfere seriously with their chance of success not only in school work but in life work. Of these ten children, there are probably two who will at some time later in life become so mentally ill that they will have to enter a mental hospital. It is a somewhat uncomfortable fact that there are about as many children in the average class in school who will later enter a mental hospital as there are children who will later enter a university. It is clear that we can no more escape our responsibility to the former than to the latter.

Not Mental Defectives

It is necessary, at this point, to warn the reader against a rather common misunderstanding. In referring to children who are in poor mental health, we are *not* referring to children who are dull or mentally inferior. It is simply an evasion to say, as some teachers do: "Yes, something should certainly be done about these dull-witted pupils who are clogging our classes and getting no benefit from our teaching. These poor-calibre children should be removed from the regular classes in order that we can get ahead with our *real* task which is to teach *normal* children."

The plain fact is that children in poor mental health *are normal children*. They are not dull-witted; they are not mentally defective; they are not inferior pupils in any sense whatever. On the contrary, as we shall see later, those of our pupils who may later have to enter mental hospital are usually superior in ability and are often among the very best pupils in our classes.

Not Abnormal

Nor are we facing facts if we suggest that these children are really abnormal and should be referred to the attention of a specialist. Children who are in poor mental health are not abnormal yet. They may be in the very earliest stages of becoming abnormal, but unless the teacher can deal intelli-

gently with them at this early stage, probably no one else will until it is too late for effective preventive treatment. Certainly, by the time such children reach the attention of a specialist, the best opportunity for successful treatment has already passed. Unhealthy habits will have become so deeply engrained that the task of replacing them with healthier habits will have become a very difficult one.

The teacher's task is precisely that of *preventing* these children from becoming abnormal. If we, as teachers, can learn to recognize the early symptoms of poor mental health—if we can learn how to deal with them intelligently in their early stages—then we can make an important contribution to the prevention of unnecessary mental illness.

Poor Mental Health in Teachers

It is not only in the interests of their pupils that teachers need to know something about how to preserve good mental health. Another somewhat uncomfortable fact which needs to be faced is that teachers, themselves, are by no means immune to mental illness.

Some authorities are of the opinion that teachers, as a group, contribute rather more than their fair share to the population of mental hospitals. The evidence on this question is not conclusive. But whether or not *severe* mental

illnesses occur any more frequently among teachers than among the members of other professional groups, it is clear that *milder* forms of mental illness are exceedingly common. Surveys of large groups of teachers have indicated that, on the average, one teacher in six is suffering from a degree of poor mental health which seriously interferes with both efficiency and satisfaction in teaching. In one study,[5] involving more than five thousand teachers, "nervousness" was found to rank second only to "colds" in frequency of mention, being reported by more than one-third of the entire group.

The frequency with which poor mental health is to be found among teachers is a fact which should neither alarm nor annoy us. At the moment we are not concerned with the possible reasons for this apparent prevalence. Naturally, we are apt to be very ready with our excuses and explanations, pointing almost with pride to the many difficulties and hardships of a teacher's existence. Actually, there is nothing whatever in a teacher's task which is inherently harmful to mental health. However, the point of importance at the moment is that teachers, as a class, have very good personal reasons for knowing something about mental health and how to preserve it in themselves.

[5] *Fit to Teach: A Study of the Health Problems of Teachers.* Ninth Yearbook, Department of Classroom Teachers, National Education Association of the United States, February, 1938, p. 32.

III

FALSE NOTIONS

THE first and most important step toward a constructive contribution in the field of mental health is the development, in ourselves, of a healthy attitude toward the subject of mental disease. This really means taking the trouble to be sure that we are rid of the needless fears and groundless superstitions which are so commonly associated with the subject.

Many people are still very much afraid of what they call "insanity." They hear or read wild stories of raving maniacs and shudder at the very mention of the subject. They imagine "insanity" to be a sort of fearful and mysterious calamity which may suddenly befall a person without any warning. When the unfortunate victim "goes crazy," he is popularly supposed to become either wildly uncontrollable and destructive or sly, treacherous, and dangerous.

Such a fanciful picture is, of course, very far from the facts. Nevertheless, it has given rise to a widespread and sometimes very intense fear of "insanity." Encouraged by sensational newspaper accounts, bad fiction, and cheap movie "thrillers," it is made possible only by general ignorance as to what mental disease really is.[1]

[1]The extremes to which this ignorance may go is illustrated by the story of the mother who is said to have sent her small son to the drug store with a note which read: "Please give Johnny ten cents'

Fears due to ignorance can in most cases be cured by accurate information. We have, therefore, a responsibility not only to rid ourselves of needless misconceptions regarding the nature of mental disease but also to assist in the eradication of such false notions in the community at large. Many of these misconceptions are a direct menace to mental health. In seeing that they are replaced by straightforward factual information, we make a significant contribution to better mental health.

Among the misconceptions which are still fairly common in our community are the following:

1. That the Mentally Ill Are "Insane" and Are Kept in "Asylums"

The word "insanity" has a very specific legal meaning. It has to do with the question of a person's responsibility for his behaviour in the eyes of the law. It is a word which may be useful in the court of law but which should be restricted to its use in that setting. Used popularly and without recognition of its strict legal meaning, it is definitely misleading. In common with a number of other words and phrases such as "losing one's mind," "going crazy," "going off one's head," etc.,

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worth of physic and ten cents' worth of menthol because I believe he is sick both physically and mentholly." One could wish that all of our misinformation on the subject were as harmless as this. Unfortunately, much of our ignorance is neither amusing nor trivial.

it implies that this one characteristic of irresponsibility is the outstanding characteristic of all those who become mentally ill. As we shall see later, this is certainly not the case.

There is another word which we would do well to eliminate from our vocabulary. This is the word "asylum." There are no such things as "insane asylums" in the Province of Ontario today. There are mental hospitals. When the medical term "mental disease" was substituted for the legal term "insanity," this represented much more than a polite gesture. It meant adoption of the idea that mental disorders are real illnesses in the medical sense of the term and, like other illnesses, are due to understandable causes. Thus, people who become mentally ill enter a mental hospital which is an institution operated by a specially trained medical and nursing staff. It is a hospital designed and equipped not only to care for, but to treat, the mentally ill. Anyone who speaks of "insane asylums" today reveals a profound ignorance of modern conditions and indicates that he is at least a quarter of a century behind the times in respect to this subject.

2. That the Mentally Ill Are All Alike

It is with surprise that some people learn that there are as many different kinds of mental disease as there are different kinds of physical disease. It

is important to realize that patients in a mental hospital are suffering from as wide a variety of illnesses as are the patients in any general hospital. Mental illnesses differ not only in kind but also in severity. Thus, there are some mental illnesses which correspond in seriousness to a slight attack of indigestion or a mild head cold, while there are other mental diseases which are much more serious and which perhaps correspond more closely to heart disease or cancer.

The fact that there are different kinds and different degrees of mental illness indicates a further fact of importance. This is, that all persons who are mentally ill are not necessarily in mental hospital. There are many people who are physically ill but who do not need to enter a general hospital. Similarly, there are many people in our community who are suffering from mild degrees of mental illness which never necessitate admission to a hospital. Thus mental disease is by no means a purely institutional problem, and mental health is as much a matter of concern in the community at large as is physical health.

3. That Mental Disease Is Due to Some One Cause

Frequently one hears the claim that most so-called "mental breakdowns" are the result of some one cause such as poor heredity or the excessive

use of alcohol or bad sex practices or over-work or worry. It should be evident from what has been said above that since there are many different kinds of mental disease, there will be many different kinds of causes. We will be discussing certain of the causes of mental illness in some detail later, but it may be said here that the alleged causes just mentioned are neither the most important nor the most frequent. Alcoholism and syphilis are observed in less than ten per cent of the cases of mental illness which come to hospital. Masturbation is no longer regarded as a causal factor in mental disease. The economic depression, with its attendant anxiety and strain, has resulted in no significant increase in the frequency of the major mental diseases.

Worry and overwork are, of course, not causes of mental illness at all. They sometimes precede mental illness but they are *symptoms* of poor mental health, *not causes* of the breakdown. (It is a significant fact of special interest to teachers who consider themselves overworked that the only people who really overwork are people in poor mental health!)

As far as heredity is concerned, it is true that both physically and mentally we are, to some extent, the products of our inheritance. However, it is equally true and even more important that inheritance does not, in itself, determine either our

physical or our mental health. In the field of mental disease, the importance of heredity has been much exaggerated. Gradually, we are getting rid of what has been very aptly described as "the doctrine of eternal damnation through heredity." It is now recognized that heredity plays no greater part in the causation of mental disease than it plays in the causation of physical disease.

There are many different causes of mental illness. No broad generalization will serve to explain all mental diseases. If we want to understand why a person had to go to a general hospital, we need to know a great deal about his history and the particular factors responsible for his individual health difficulty. The same is true of a person who has had to enter a mental hospital.

4. That a Mental Disease Is Incurable

There are still people in our community who show by their expression, when the subject is mentioned, that they think mental diseases are usually fatal or, at least, incurable. That this is not the case is shown by the fact that, during 1938, more than two thousand persons were discharged from the mental hospitals of this Province because, after treatment, they were sufficiently recovered or improved to carry along satisfactorily in the community. Indeed, recovery rates from

mental hospitals today compare favourably with recovery rates from general hospitals.

It is true that patients who have recovered from a mental illness may subsequently become ill again. However, this is not in the least peculiar to mental diseases. When a person leaves a general hospital after recovery from a physical illness he takes with him no guarantee of permanent physical health. There is no greater tendency to recurrence in mental disease than there is in physical disease.

5. That Mental Illness Is Sudden in Onset

It is now known that most mental illnesses have a long history of slow and gradual development. It is true that many breakdowns seem to us to occur very suddenly and without any warning. However, this is really because we fail to recognize the earlier indications of poor mental health when they occur and, therefore, when the breakdown finally comes, we are surprised that we saw no warning signs. The warning signs were there. We simply did not see them.

6. That Mental Disease Is Inevitable

Whenever we do not know what causes any event, it always appears inevitable to us. In ancient times, plagues were inevitable. Even in more recent times, typhoid fever, smallpox, and diphtheria were regarded as inevitable diseases.

Today, our knowledge makes these and many other diseases largely preventable. Enough is already known about what causes many mental diseases to make them by no means inevitable but very definitely preventable.

7. That Mental Disease Is a Disgrace

There still persists a tendency to regard mental disease as something which must be hushed up or mentioned only furtively. In one sense, of course, any illness, whether physical or mental, is a disgrace if it was unnecessary and could have been prevented. But the disgrace should really be attached to a society which fails to take the necessary precautions and particularly to parents and teachers who fail to lay that foundation of good physical, mental, and emotional habits upon which adult health is based. As stated above, mental diseases are no more indicative of bad family background than are physical diseases, and we are gradually coming to recognize that there is no more reason to attach disgrace or shame to the one than to the other.

8. That the Mentally Ill Are Mental Defectives

One of the most persistent misconceptions in this field is the notion that mental disease and mental defect are synonymous terms. Probably

this is partly because certain mental hospitals are usually assigned the special task of caring for mental defectives. For example in this Province, the Ontario Hospital School at Orillia is an institution exclusively devoted to the care and training of mental defectives. It is a fact of importance, however, that the patients in this particular institution are entirely different from those to be found in the other Ontario Mental Hospitals whose task it is to treat the mentally ill.

Failure to distinguish clearly between mental disease on the one hand and mental defect on the other has given rise to the misleading notion that our mental hospitals are filled with inferior types of people whose removal from the community is probably a good thing in any event.

This is emphatically not the case. The people who enter our mental hospitals because of mental illness do not come from the poorer calibre of our population. They are not mainly either "undesirable aliens" or "dull-witted ne'er-do-wells." As a group, they are good Canadian citizens of at least average intelligence, who have had rather more than the average degree of education. In many instances, they were leaders in the communities from which they came and their removal to hospital has meant a serious loss to those communities.

The patients now in our mental hospitals, when they were in school were children of normal or even superior intelligence. That is why our major interest throughout this book is with normal or superior, rather than with dull or backward, pupils. Nevertheless, there are certain aspects of the problem of mental defect which are important to teachers and it is proposed to discuss these in the next two chapters.

Summary

In ridding ourselves of certain false notions concerning mental disease, such as those which have been discussed above, we provide ourselves with a sound basis of positive knowledge upon which to develop a healthy attitude toward the subject. We eliminate from our vocabulary such outworn and misleading words as "insanity" and "asylum." We recognize that there are many different kinds and degrees of mental illness produced by a wide variety of causes; that mental disease is not usually either sudden in onset or fatal in outcome; that most mental diseases have a long history of gradual development during which preventive measures might be taken; and finally, that there is no more reason to be ashamed of a mental disease than of a physical disease.

With this as a general background, we may now proceed to examine in more detail specific

types of mental disease and the specific causal factors which seem to be responsible for them. In doing this, it will be useful to start by recognizing a clear-cut distinction between mental defect and mental disease proper.

IV

MENTAL DEFECT: A MINOR PROBLEM

THE mental defective has been receiving an increasing amount of public attention in recent years. In many popular discussions, however, the difficulty of the problem, which is already great enough, has been considerably increased by an apparent confusion of the terms "mental defect" and "mental disease." It is important, therefore, to have clearly before us the distinction which exists between these two conditions. Mental defectives are not mentally ill—and the mentally ill are not mental defectives. They constitute two quite separate groups; they present quite different problems; they must be dealt with in quite different ways.

An analogy may help to clarify this difference. We have no difficulty in distinguishing between people who are physically sick and people who are physically short. The former are physically *abnormal;* the latter are physically *subnormal* (in respect to height). Now, the mentally ill are persons who are mentally and emotionally sick. Mental defectives, on the other hand, are simply short—short in mental ability—short in that particular characteristic we call "intelligence" or "general ability." They may be, and in most cases are, perfectly healthy both physically and

mentally. They are simply subnormal—below the average in "mental stature."

Mental defectives constitute only a small proportion of the patients in our mental hospitals. Only one of the fourteen mental hospitals in Ontario is devoted exclusively to the care and training of these cases. The other mental hospitals are concerned with the treatment of the mentally ill. Thus, mental defect presents a problem which is really of minor importance in comparison with the problem of mental disease.

Nature of Mental Defect

It is to mental defectives and to them only that the terms "subnormal" and "feebleminded" should be applied. These are persons suffering from some degree of intellectual inferiority. This relative subnormality of intelligence exists at birth and remains unchanged throughout life.

All mental defectives do not show the same degree of deficiency. If we examine any large group of persons, we will find that the individuals in the group differ from one another in their ability or intelligence just as they differ in height. Some of them will be "short." But just how high is a "short" person? Obviously there are no clearly marked divisions between the short, the average, and the tall persons in the group. In the same way, there are no clearly marked divisions between

the mental defective, the normal, and the superior persons. Each group blends imperceptibly into the next and any divisions which are drawn are entirely arbitrary.

From this, it should be apparent that the feebleminded are not a distinct group; that they are not a different kind or type of human being; that they simply lack in more or less degree that characteristic which may be described as the ability to behave intelligently. They range all the way from the almost totally helpless idiot to the high-grade moron of perfectly normal appearance who can, and in most cases does, carry on as a normal and useful citizen.

Causes of Mental Defect

There are many different causes of feeblemindedness. Much remains to be discovered about the factors which are responsible for mental defect, but it is known that, in certain cases, the condition is due to glandular disturbances in the child; in others, it is due to abnormal physical conditions in the mother during pregnancy; in still other cases, mental defect is the result of birth injuries or gross damage to the brain after birth. (Contrary to what has been supposed, neither alcoholism nor syphilis in the parents appears to be an important causal factor in producing mental defect in offspring.)

The important point, however, is that there are many different causes of mental defect. Much confusion has resulted from the unwarranted assumption that there is only *one* cause of feeble-mindedness; namely, feebleminded parents. One reason for the popular notion that most, if not all, mental defectives inherit their defect directly from their parents, is our natural tendency to be impressed by specially selected family histories which purport to show how mental defect has persisted and multiplied through several generations.

From a scientific point of view such "family trees" as those of the famous Kallikaks and Jukes[1] are evidence merely of the extent to which misguided enthusiasm may supplant factual information. What is seriously at fault in these famous stories is the method of determining mental defect in remote ancestors. The solemn diagnosis of mental defect in a great-great-grandfather on the basis of third-hand hearsay gossip would be amusing if it were not so misleading. Such myths regarding the supposed fruit of certain alleged family trees sound very convincing but are now

[1]Two family groups in which the alleged feeblemindedness of an ancestor is supposed to have been responsible for the presence of many mental defectives in subsequent generations. They have been frequently cited, as evidence of the "Menace of Mental Defect." For the original stories, see: R. L. Dugdale, *The Jukes* (G. P. Putnam's Sons, 1877); A. E. Winship, *Jukes-Edwards* (Meyers, 1900); H. H. Goddard, *The Kallikak Family* (Macmillan, 1912).

recognized as scientifically worthless because of the unsound methods employed in their construction.

Fortunately, we are no longer in the position of having to depend upon vague speculations and uncertain opinions concerning the presence or absence of mental defect in previous generations. Gradually, evidence is accumulating which is based on the direct observation and psychiatric diagnosis of those concerned. One example of this is the series of individual examinations given by Dr. Cyril Burt to all pupils in the London County Schools over a period of nearly thirty years. The maintenance of this programme over such a long period of time means that the pupils now being examined are in most cases the offspring of parents who were themselves similarly examined years ago. Thus, a type of direct factual evidence on the question is becoming available.

It is commonly supposed that the majority of mental defectives are born to feebleminded parents. That this is not so is shown clearly by Burt's report[2] that, in only six per cent of the mental defectives now in these schools, was either the father or mother feebleminded.

It is commonly supposed that the majority of children born to mental defectives will be feeble-

[2]C. Burt, *The Subnormal Mind* (ed. 2, Oxford University Press, 1937), chap. 11.

minded. This opinion is also found to be contrary to the facts. Of five hundred children known to be the offspring of mentally defective parents, Burt found only fourteen per cent to be feeble-minded. The evidence indicates that the offspring of mental defectives tend to be more intelligent, not less intelligent, than their parents.

Mental defect is a result, not of a single cause, but of a wide variety of different causes. Far less is known about the inheritance of mental defect than is commonly supposed. Claims that it is inherited as a Mendelian recessive are based on evidence which does not stand criticism in the light of modern statistical requirements. There is reason to believe that the investigations which are now being made into the physiological and biochemical factors, which are so important for normal prenatal growth, may throw much greater light on the specific factors which interfere with the development of normal intelligence.

Extent of the Problem

That the subnormal in the community constitutes a serious problem needs no emphasis. Just what the extent of that problem is, can be readily determined. Although the exact number of mental defectives in our Province is not known, careful surveys of large populations elsewhere provide a reliable basis for calculating that there are between

60,000 and 70,000 mental defectives living in the Province of Ontario today.

Since only about 2,000 of these are to be found in our institutions and less than 5,000 others have been identified by schools and welfare agencies in the community, it is interesting to note the very significant fact that at least ninety per cent of our mental defectives are able to maintain themselves in the community without ever being recognized as such either by institutional authorities or by social agencies.

Is Mental Deficiency Increasing?

Any reference to the number of mental defectives in the community is certain to raise the question of whether mental defect is increasing in frequency. One often hears it said that mental deficiency is increasing at an alarming rate. Certain public-spirited citizens, blest with more zeal than information, have even suggested that the salvation of the race depends upon the immediate employment of eugenic means to curb the menace of mental deficiency.

Such a view is based on two assumptions: first, that mental defect is caused by feebleminded parentage; and second, that mental defectives have large families and, therefore, propagate more rapidly than do persons of normal intelligence. The first assumption has already been discussed.

There are many causes of mental defect and feebleminded parentage is certainly not as important as has been supposed. But even if this assumption were well-founded, the second assumption runs contrary to the facts.

In a recent very careful investigation,[3] it was found that mental defectives themselves have *less* than the average number of children: that for mental defectives, the birth-rate is lower, the marriage-rate is lower, and the death-rate is higher than for the general population.

Thus, it is difficult to see any valid reason for supposing that mental defectives are becoming any more numerous or for arousing public anxiety concerning the "menace of mental deficiency."

It is, of course, true of mental defectives as it is of the mentally ill, that there are more of them in institutions today than there were years ago. But here again this does not mean that mental defectives are on the increase. It simply means that we have improved our methods of diagnosis, that we have extended our facilities for treatment, and that we are more conscious of the importance of this factor in community adjustment.

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[3]Committee of the American Neurological Association for the investigation of Eugenical Sterilization, *Eugenical Sterilization: A Reorientation of the Problem* (Macmillan, 1936).

V

MENTAL DEFECT: PROPOSED SOLUTIONS

Registration

ONE of the earliest proposals was the suggestion that the entire population should be carefully surveyed and examined in order that all mental defectives could be identified and their number, location, and condition made known to the authorities. It soon became apparent that simple identification of mental defectives would serve no useful purpose whatever since it would be both impossible and unnecessary to do anything about the large majority of them.

Segregation

Linked with the idea of registration was the notion that mental defectives should really be removed from the community and placed in suitable institutions. The sheer economic impossibility of any such grandiose scheme rapidly became apparent. For example, in Ontario, if we disregard entirely the capital cost of building institutions, it still costs the Province one-half million dollars each year to maintain two thousand mental defectives in institutions. Even if additional institutions could be obtained without expense, the segregation of all mental defectives in Ontario would increase this maintenance cost to more than fifteen million dollars annually. It is evident that,

even if it were desirable, the institutional segregation of mental defectives is simply not practicable.

Sterilization

A more recent proposal is that of eugenic sterilization of mental defectives. This has become a highly controversial subject because, for many people, it involves not only scientific issues but moral and religious issues as well. It must be understood that anything that is said here will be limited strictly to the scientific issues involved.

The first requirement is to be clear as to what is being discussed. Unfortunately, eugenic sterilization has sometimes been proposed as a sort of cure-all for most of society's ills. It has been proposed in connection not only with mental defect but also with mental disease, criminality, immorality, and almost every other major problem in society. Discussion without definition is futile. Our present discussion is limited to the question of the sterilization of mental defectives.

The sterilization of mental defectives has usually been advocated on the grounds that mental deficiency is increasing at an alarming rate and that such a procedure would serve to eliminate this undesirable strain from the population. As a matter of fact neither of these arguments is valid. In the first place, as noted above, there is no evidence that mental defectives are increasing in

proportion to the population; in the second place, feebleminded parentage is by no means the only cause of mental defect and it is obvious that sterilization would have no effect on the large proportion of cases born to normal parents.

Stated briefly, there is no reason to fear that, without sterilization, mental defectives will swamp the population, nor is there any reason to hope that, with sterilization, the problem of the feeble-minded will be solved or even materially reduced.

In ridding ourselves of exaggerated fears and false hopes concerning sterilization, we should not conclude that the question is settled. While recognizing that sterilization is no panacea, an impartial survey of the facts will indicate that there still remain valid scientific grounds for giving serious consideration to the adoption of some form of voluntary selective sterilization.

Successful parenthood and the effective training of children are tasks which call for no small measure of ability. It is obvious that mental defectives are handicapped in the effort to provide for their children the sort of environment and the type of training which will be likely to produce socially desirable citizens. It must not be for-gotten that many mental defectives are able to maintain a healthy, happy, and independent home as long as their family is limited to a few children. As the number of children increases, however, the

economic burden becomes too great, the home begins to deteriorate, and eventually the whole family may, and often does, become a charge on the state either through relief or institutionalization. This constitutes a very practical social problem and there is little doubt that some form of voluntary selective sterilization would enable many mental defectives satisfactorily to maintain themselves and their families in the community.

Recognizing that sterilization might have some practical, if limited, value in dealing with certain aspects of the problem, it must be frankly admitted that mental defectives cannot be legislated out of existence and that there are no simple easy solutions to the problem they present. There is, however, another approach to the problem which has already shown such promising results that it warrants further development.

Education and Supervision

The modern approach to the problem of mental deficiency may be described as one of special education and community supervision. It must not be thought that the training of mental defectives is either a hopeless or a worthless procedure. The feebleminded, no matter how defective, are never "ineducable." They can be, and are being, made both useful and happy through special training. Except in a few very extreme cases, this

special education does not depend on institutionalization. In most cases, they can be satisfactorily trained in the community—in their own schools and in their own homes.

The special education of mental defectives in the community does not mean simply special academic training in so-called auxiliary classes. It is true that such classes do offer many of them their first opportunity to learn in a healthy fashion those few academic skills which are of practical value. But this is only one aspect of their training. Another aspect of equal importance is a type of occupational training suited to their level of ability which will enable them to earn their living as productive members of society.

More important, however, than either academic or occupational education is that broad social training which will largely determine whether or not they can remain in the community. The only mental defectives who present serious problems are those who have not learned how to live in a socially acceptable manner. It must be remembered that mental defectives are not the only ones who sometimes fail to learn how to do this. There are others of normal, and many of superior, intelligence who have similarly failed and who require that very difficult type of social re-education called "reformation." And it happens that the social re-education of the defective delinquent is precisely

the same problem as the social re-education of any other type of delinquent. Mental defectives are no harder and no easier to reform.

Mental Defect and Delinquency

A quarter of a century ago, it was thought that mental deficiency was a major cause of crime and delinquency. Surveys of reformatories and prisons revealed that a relatively large proportion of mental defectives were to be found among the inmates of such institutions. From this, it was concluded that crime is often due to mental defect. It has even become popular to attribute vice, immorality, and incorrigibility to the mental defective. It is supposed by many that he is highly suggestible and, therefore, easily led astray.

Among those who have had direct experience in working with large groups of mental defectives these superstitions have long since evaporated. We now know that mental defectives do not tend to be vicious, immoral, brutal, or criminally inclined. It is still true that mental defectives are found in reformatories and prisons with disproportionate frequency. However, this is not because mental defectives tend to be criminals, but simply because mental defectives tend to be *caught*.

Like the rest of us, mental defectives need to be taught how to behave in a socially acceptable manner. It is simply because society has so often

failed to provide anything in the way of suitable social training that mental defectives have gained their ill repute.

Teachers sometimes show an unfortunate tendency to use mental defect as a scapegoat for their sins. Having determined that the troublesome child is mentally defective, we are apt to imagine that we have explained the troublesomeness. But a mental defective gives trouble for precisely the same reasons as does a normal child. It does not follow that the mental defective should go to an institution. It *does* follow that whatever social treatment is indicated in the one case is likewise indicated in the other case. We are unduly impressed with the mental defectives who come to our attention because they have got into difficulties. It is, therefore, worth remembering that at least ninety per cent of mental defectives never come to our attention at all because they do *not* get into difficulties.

Mental Defectives in School

There is no known way of altering the amount of a person's native intelligence. It is fixed at birth and remains constant throughout life. Thus, mental defectives cannot be made more intelligent by any known type of education. They can, however, be made more efficient and their proper

training is a matter of considerable importance to society.

As far as teachers are concerned there are certain important implications which grow out of a proper understanding of feeblemindedness. Obviously, it would be as senseless to whip a weak child for failing to lift a heavy weight as to punish a mentally defective child for failing to add or spell correctly. But teachers are apt to make the mistake of thinking that they know when they are dealing with a feebleminded pupil. Unfortunately, neither a teacher nor a psychologist nor a psychiatrist can identify a mental defective by his appearance. Our popular notions that the shape of the head, the height of the forehead, the facial expression, or perhaps the open mouth and vacant stare are reliable indications of ability or its absence, are entirely unfounded.

Even backwardness in school work or apparent inability to learn cannot be taken as reliable clues to mental defect. Of a group of more than one thousand children, who were referred by teachers in this Province for examination because of poor school progress, less than half were actually found to be defective in intelligence. There are many other reasons for failure at school. The only way to determine the degree of a pupil's intelligence is

to arrange for a careful examination by a competent psychometrist.[1]

The modern school is now making provision for the special training to which children of retarded ability are entitled. It is perhaps unfortunate that these children have had to be segregated in special classes. However, as the content of the curriculum for normal children becomes more practical and useful, and less emphasis is placed on speed competitions and artificial grades, it may eventually be possible for the normal child in school to benefit from the excellent training which defective children have been receiving in these special classes. Segregation will then no longer be required.

The foregoing discussion has been somewhat in the nature of a digression designed to indicate that mental defect is a distinct and separate problem. We will return now to the major problem which is that of mental disease. Henceforth, our interest is centred in children whose efficiency and satisfaction in living are jeopardized, not by lack of intelligence, but by lack of sound mental and emotional health.

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[1]Facilities for such examination are made available to teachers in this Province by the Department of Education (Inspector of Auxiliary Classes) and the Department of Health (Provincial Mental Health Clinics). Requests are made through Principals, Inspectors, or School Medical Officers.

VI

MENTAL DISEASE: THE MAJOR PROBLEM

IMPORTANT though it may seem, the problem of mental defect is really of minor significance when compared to the much more serious and difficult problem presented by mental disease. The fact is that most mental defectives are happy, healthy, and useful citizens. Only a very small proportion of them ever require institutional care. Altogether, they constitute less than fifteen per cent of the persons in our mental hospitals. Thus, the major problem, and the one to which the remainder of our discussion will be directed, is the problem of mental disease.

Unlike mental defect, which is a subnormality of intelligence usually existing from an early age and remaining unchanged throughout life, mental disease is a disorder or disturbance which, like any other illness, occurs in a person who may have appeared previously normal and who may, on recovery, become normal again.

It will be recalled from our earlier discussion that there are many different kinds and degrees of mental disease produced by a wide variety of causes. It is important that we have some fairly definite information about the characteristics of these various types of mental disease and, especially, that we gain some understanding of the causal factors which are responsible for their

occurrence. Only in this way can we hope to rid ourselves of the vagueness and uncertainty with which the subject is otherwise likely to be viewed.

In describing the various forms of mental illness to be found in mental hospital, we shall dispense with technical terminology and try to limit ourselves to ordinary descriptive words which, though less exact, are more readily understood. It seems likely that one of the reasons for the widespread fear associated with mental disease is the wholly unfamiliar and rather awe-inspiring names which have been given to certain of these conditions. To hear that a person is suffering from "cerebral arteriosclerosis" or "hebephrenic schizophrenia" is, in itself, enough to make most laymen view the situation with alarm. For our present purpose, technical terms are neither necessary nor helpful. Our objective is simply to gain a clearer notion of what the more common mental diseases are like and what causes them.

Types of Mental Disease

Certain mental diseases are due directly to an underlying physical or organic condition. In other mental diseases, there is no known physical basis for the mental disturbance. This difference is sometimes used to classify mental diseases as either "organic" or "functional."

"Organic" Type

About one-third of the patients in mental hospitals are suffering from mental diseases which may be classified as "organic." Among these are to be found the following:

Brain Injuries

In these patients, mental disturbances are the direct result of falls, bruises, fractures, wounds, or other accidents which cause injury to the brain or nervous system. Such accidental injuries are, of course, relatively infrequent but when they do occur the problem is a purely medical one of dealing as effectively as possible with the organic or physical damage.

Brain Diseases

In these, the mental condition of the patient is due to certain specific infective agents which attack the brain or nervous system. Again, treatment is a purely medical problem. As for prevention, all that is required is reasonable attention to general physical hygiene with sufficient in the way of medical supervision to ensure the early detection of any such infection if it should occur. Certainly, this type of mental disease is no more mysterious than any of the other infections to which the human body is susceptible.

Senility

It is common knowledge that when a person reaches a very advanced age, his body tends to function less efficiently. Like other parts of his body, the brain, the nervous system, the arteries, etc., have undergone changes which to a greater or lesser extent interfere with his ability to behave smoothly and satisfactorily. In certain people, these changes consequent on growing old are exaggerated and their forgetfulness, mental confusion, and childish outbursts make it desirable that they should be cared for in hospital. Thus, the senile patients in our mental hospitals are simply those in whom the natural consequences of old age are somewhat more extreme and troublesome than usual.

Poisons

We are all familiar with the mental disturbances observed in a delirium caused by fever. We also know that an intoxicated person may show quite marked mental and emotional peculiarities. Certain chemical substances, when present in the body in sufficient quantities, act as poisons and produce marked changes in mental functioning. Some of these substances gain admission to the body in the form of alcohol or other drugs; others are produced within the body and are absorbed into the system from centres of infection. Treat-

ment of the mental disturbances caused by poisons is obviously a matter of locating and, if possible, removing the source of intoxication whether this be external or internal.

Epilepsy

Strictly speaking, there is no single disease entity indicated by the word epilepsy. As used popularly, it describes a wide variety of conditions which have one outstanding symptom in common. This symptom is convulsive seizures.

Although these conditions may be classified as organic, it is not always possible to determine what particular physical condition is responsible for the convulsive seizures. In some of these conditions, but not in all, the illness is accompanied by mental disturbance.

The dramatic and sometimes violent nature of convulsive seizures has served to create very intense popular fear of these illnesses. One may even encounter the view that a person suffering from epilepsy would be better dead. Such an attitude is, today, unpardonably ignorant. The fact is that, in the majority of cases, convulsive seizures can now be controlled if medical treatment is commenced promptly. Once control has been established, the continued prevention of seizures depends, in large measure, on the care and persistence with which treatment instructions are

followed by the patient and his relatives. Certainly there is no longer any reason to regard an epileptic as the helpless victim of a tragic malady.

Summary

In organic mental diseases, such as those which have been described, treatment means dealing with the underlying physical conditions responsible for the illness. Prevention is a matter of ordinary physical hygiene and medical supervision. There is nothing particularly mysterious about these conditions and certainly nothing to justify the fear with which they are so commonly regarded.

"Functional" Type

We turn now to the so-called "functional" mental illnesses which, as far as is known at the present time, have no physical or organic basis. Nearly two-thirds of the patients being treated in mental hospitals are suffering from mental diseases of this type. Since it is in respect to the prevention of this type of mental illness that teachers can be expected to take the most active and intelligent interest, these conditions will be described in somewhat greater detail.

Functional mental illnesses are found in adults[1] who have developed, to an extreme degree, unhealthy habits of adjusting to difficulty. All of us

[1]Actual mental disease is very seldom observed in children.

in the course of living encounter obstacles which block certain of our desires. All of us, from time to time, suffer from strong but conflicting desires which are incompatible. Thus, the thwarting of some of our desires, hopes, wishes, and ambitions is just as inevitable and normal as breathing. As far as our mental health is concerned, it is not the frequency of blocked ambitions nor the severity of internal conflicts which is really important. What *is* important is the method we use in dealing with such difficulties when they occur.

Our ways of adjusting to difficulty tend to become habitual. Certain of these habits of adjustment are healthy; others are unhealthy. In discussing the main types of functional mental illness, we propose to describe them in terms of the unhealthy method of adjustment which has become so habitual and so extreme as to constitute the most outstanding characteristic of each type.

At this point, however, a word of caution may be in order. In dispensing with obscure technical terminology, we limit ourselves to ordinary words and descriptive phrases which are readily understood. Thus, the reader is almost certain to recognize these unhealthy habits of adjustment and be impressed with the extent to which many of his friends employ such methods in dealing with their difficulties. If he is gifted with much

insight, the alert reader will also realize that he, himself, makes some use of these same methods. However, this does *not* mean that he and his friends are either mentally ill or becoming mentally ill.

It is true that none of us is in perfect mental health, just as none of us is in perfect physical health. But this does not mean that we are all sick. Even if the difference is mainly one of degree, it is nevertheless a very important difference. Thus, although unhealthy habits of adjustment are employed to some extent by everyone, they are used by the mentally ill in a form so extreme that the person becomes not only incapable of carrying on his normal activities but to a large extent isolated from the real world in which he lives.

The "Ostrich" Method

One way of dealing with a difficulty is to put your head in the sand (or in the clouds) and pretend that the difficulty is really not there at all. In some of the mentally ill, this habit of refusing to face disagreeable facts has become so persistent and so exaggerated that they finally manage to escape into an imaginary world of their own construction. This imaginary world has little relation to the real world around them but it has the important advantage that there are in it none of

the real obstacles and real difficulties which they refuse to face.

Of the various types of mental disease, this is by far the most frequent. Nearly one-half of all patients in mental hospital are suffering from some form of this illness. Many of them are apathetic drifters whose careless and untidy appearance reflects their indifference to the real world around them. Others, by their silly laughter and bizarre actions, give evidence that they are living in a dream-world of their own making. Still others become mute or stuporous and indicate the extent of their divorce from reality by periods of rigid negativism or passive flexibility.

Such patients are suffering from a type of mental illness which is often very difficult to treat. One reason for this seems to be that these conditions develop very slowly over a long period of time. In most cases, they can be traced back to unhealthy habits of reacting to difficulty which had their origin in childhood.

In classrooms every day, teachers are dealing with children who are trying out this method of dealing with their difficulties. Such children are not sick or abnormal. They are, simply trying to discover whether they can escape from a real world which, for some reason, has become disagreeable to them, by looking for their satisfactions in a private world of their own imagining. There

is nothing serious about this method of evasion when it is observed in children. However, if it is encouraged and allowed to develop into a chronic habit, it may become serious.

Many patients now in mental hospital, when they were in school, gave indications that they were trying out this "ostrich" method of adjusting to difficulty. Their teachers were in a position to observe these early symptoms of poor mental health and do something to correct faulty habits of adjustment. But their teachers did not recognize either the symptoms or their importance for the future mental health of their pupils. Our interest in the sections which follow is that teachers should know what these symptoms are and what can be done to prevent unhealthy methods of adjustment from becoming habitual.

The "Addict" Method

There is another type of functional mental illness which, though less frequent than the type described above, is found in a large number of mental hospital patients. The most striking feature of this condition is lack of emotional balance. These patients may become extremely excited or abnormally depressed and remain so for considerable periods of time. In some cases, the patient may swing from one of these extremes to the other.

The exact manner in which this disorder de-

velops is not known. However, it *is* known that an intense emotion is always accompanied by important and widespread chemical changes inside the body. The nature of these changes is such that whenever we indulge in a violent outburst of emotion we unwittingly give ourselves the equivalent of a very potent drug injection.

It appears that some people become addicted to the habit of giving themselves a dose of these self-manufactured drugs whenever they encounter difficulties. They become incapable of facing a disagreeable fact such as personal failure without becoming intensely upset. In order to escape unpleasant realities, they habitually go off on an emotional "spree."

This infantile method of reacting to difficulty is very commonly observed among children. If it is permitted to become an habitual way of dealing with all difficulties, it results in a degree of emotional instability which jeopardizes mental health. It seems evident that early training in the healthy control of emotion and assistance in achieving emotional maturity are among the most important contributions which we can make to the preservation of sound mental health.

The "Corkscrew" Method

There are some clever people who manage to evade their difficulties by means of a sort of twisted thinking which enables them, at least to

their own satisfaction, to escape any feeling of personal responsibility for their failures. Having failed, they promptly offer ingenious and logical-sounding "reasons" why failure was inevitable and certainly not due to any mistakes on their part. They may even build around themselves a protective wall of these elaborate "explanations" or alibis behind which they can always hide whenever they encounter difficulty.

There is in all of us, of course, a strong tendency to indulge in twisted thinking of this sort. In its milder forms, therefore, it is neither unusual nor abnormal. However, in an extremely exaggerated form, this method of evading difficulties is the outstanding characteristic of another type of functional mental illness. Patients suffering from this disease develop fantastic notions that they are the innocent victims of constant persecution by implacable enemies. In this way they manage to place the blame for all their troubles on imaginary persecutors and never for a moment face the possibility that they, themselves, have been in any way responsible for their difficulties.

Intellectual self-deception is one way of dodging reality but it is clearly not a healthy method of adjusting to difficulty.

The "Invalid" Method

Another way of evading difficulties is by the simple device of being sick. Illness is nearly

always regarded as an acceptable excuse. It is natural, then, that many people in trying to escape from a difficult or trying situation should hit upon illness as a solution. We are all more or less familiar with "housewife's headache" which provides such a convenient means of escape from disagreeable tasks. But there is also the husband whose arthritis becomes most severe when there is any work to be done around the house. There is even the youngster who is much too sick to go to school until half past nine but recovers rapidly when there is no longer any danger of having to go.

Many of these illnesses are so transparent that they do not succeed in fooling anyone except, perhaps, the person who is using them. Yet we make a serious mistake if we suppose that all illnesses of this convenient type are simply deliberate pretences. Experience with so-called "shell-shocked" cases during the war demonstrated once and for all that many of these illnesses represent an entirely unintentional reaction which is not under the person's voluntary control but which does serve to free him from an intolerable situation.

It is not only under war conditions, however, that a person may employ this method of invalidism as a way of escape. The method is widely used by civilians and, in some of them, becomes an habitual way of evading difficulties. Even in

such cases, however, the degree of mental illness which results is usually slight and is of a kind which seldom calls for mental hospital treatment.

In some cases, this type of mild mental illness takes the form of always being "too tired" to do the things they do not want to do. Others become persistent "worriers" and live their lives in a miserable haze of real but self-induced anxiety. (They are never at a loss for something to worry about since there is always the next war, or the economic depression, or other people's morals, or some other convenient excuse.) Others become chronic "disease hunters" constantly searching in themselves for new and better diseases, unaware of the fact that what they really want is a plausible excuse for failure and inadequacy. Some wander from doctor to doctor being told that there is nothing organically wrong with them until, finally, they fall into the hands of some "healer" who is sufficiently sympathetic (and unscrupulous) to play up to their fantasies of illness. Others prefer to wander from drug store to drug store busily collecting large supplies of expensive but worthless "remedies" for their imaginary ailments.

To dismiss such illnesses by saying that the person "is not *really* sick but *just thinks* there is something the matter with him" is to miss the point entirely. The important fact is that, to the patient, these illnesses are just as "real" as any

other sort of illness. It was a very shrewd physician who observed that "the person who is so ill that he thinks he is ill, when he is not ill at all, is very ill indeed."

Conclusion

In describing the main types of mental illness, our purpose has been to show that there is nothing so weird and mysterious about mental diseases as we are apt to suppose. They are real illnesses resulting from understandable causes about which we can, if we wish, do something constructive. A study of those who have become mentally ill indicates that, in most cases, the origin of the illness can be traced back to unhealthy methods of adjustment which were adopted in childhood and which were permitted to become habitual. These methods were, in the early stages, natural and normal efforts to evade difficulties. All that was needed at that time was the quiet and intelligent assistance of some informed person who might have encouraged the development of healthier habits of adjustment.

VII

PREVENTING MENTAL ILLNESS

THOSE types of mental disease which are due directly to underlying organic causes present treatment problems which are essentially medical in nature. Similarly, the task of preventing organic mental illness is primarily a medical responsibility. Thus, our main interest as teachers, is in that other and larger group of patients suffering from functional mental illness.

Careful study of these patients has shown that, in nearly all cases, a functional mental illness is not sudden in onset but, on the contrary, has had a long history of slow and gradual development. Indeed, most of these patients are found to have shown distinctive characteristics long before there was any direct evidence of an actual mental disease. Even as children in school, most of them displayed early indications of poor mental health.

These are the facts which make the prevention of functional mental illnesses a direct challenge to teachers. This challenge is not that teachers should provide early treatment for people who are already somewhat abnormal. The challenge is simply that teachers should provide intelligent handling for children who are normal in order that they may stay normal. The early indications of poor mental health which children show in school are not symptoms of mental abnormality.

They do not indicate that a child is mentally ill or that he need become mentally ill. They are simply early indications that a normal child needs intelligent help in preserving his normality.

What, then, are these early indications of poor mental health in children? Where should teachers look and what should they look for if they wish to make a constructive contribution to better mental health in school?

Unfortunately, it is necessary to begin by facing an important, if somewhat uncomfortable, fact. Teachers customarily either ignore or admire (and, therefore, encourage) those forms of behaviour which reflect poor mental health in their pupils. *This is not said in criticism of teachers.* It is simply true that those children whom the teacher is likely to regard as "good" are usually in poorer mental health than those children whom the teacher is likely to regard as "bad."

Several recent studies[1] on teachers' attitudes toward pupil behaviour have shown that teachers

[1] E. K. Wickman, *Children's Behaviour and Teachers' Attitudes* (New York, Commonwealth Fund, 1928); J. Yourman, "Children Identified by Their Teachers as Problems" (*Journal of Educational Sociology*, 1932, V, 334-43); R. M. Stogdill, "Attitudes of Parents, Students and Mental Hygienists toward Children's Behaviour" (*Journal of Social Psychology*, 1933, IV, 486-9); S. R. Laycock, "Teachers' Reactions to Maladjustments of School Children" (*British Journal of Educational Psychology*, 1934, IV, 11-29); R. H. MacClenathan, "Teachers and Parents Study Children's Behaviour" (*Journal of Educational Sociology*, 1934, VII, 325-33).

regard as most serious those forms of aggressive misbehaviour which create a disturbance, interfere with the classroom routine, or violate the teacher's own personal standards of deportment. This is a natural attitude for teachers to take. The aggressive, experimental, obstreperous, misbehaving child gives us almost constant trouble and, therefore, represents our idea of the "problem child." In contrast, the quiet, compliant, submissive, obedient child gives us no trouble and, therefore, represents what is most desirable and laudable in pupil behaviour. Yet it happens that the amount of trouble a child gives us is not a valid measure of his mental health. In fact, the chances are that the extremely aggressive child is in better mental health than the extremely submissive child.

Of course, no one would argue that either of these extremes is really desirable. Both are indications of failure in social adjustment. Both represent unsuccessful efforts to solve difficulties—in the one case, by violent attack; in the other, by evasive withdrawal. But the child who, in school, develops habits of attack and who reveals this trend by persistent violation of regulations, disobedience, defiance, fighting, and truancy, is likely to grow up into an adult who is also aggressive and independent, who does not hesitate to break conventions and who may, therefore, become a very resourceful leader, militant reformer, or enter-

prising business man. He may, of course, become so aggressive as to break laws unskilfully and end up in a penitentiary, but the point of importance for our present discussion is that, whatever happens to him, he will probably not end up in a mental hospital.

Our mental hospitals, on the other hand, are dealing mainly with people who, when they were children in school, presented quite a different picture from that just described. The child who is quiet, submissive, shy, and timid in school is likely to grow up into an adult who is somewhat seclusive and socially ill at ease. He may, if he is fortunate, find a type of work which is congenial and make important contributions in literature, art, invention, research, or some other more or less individualistic pursuit. But, in our modern world, the way of the recluse is hard. Complete isolation from contact with one's fellows is difficult, if not impossible, to achieve and maintain. Failing such isolation, he may be driven to more drastic methods of social withdrawal, and it is among persons of this type that functional mental illnesses are most likely to occur.

This contrast between the aggressive and submissive child with respect to their future development has been deliberately exaggerated. It is important to remember that all children who are extremely aggressive in school do not end their days in a

penitentiary (even though we may be tempted to predict such a fate). Likewise all children who are extremely submissive in school do not find their way into a mental hospital. In most cases, such extreme characteristics become less exaggerated as the child grows up. There is no evident reason why either tendency should be permitted to persist or become more extreme.

Children are not born with these characteristics. For the most part they are acquired in the same way that other undesirable habits are acquired. Whether such habits become more or less extreme depends very much on what we do about them.

Our present interest is in the possibility of preventing unnecessary mental illness. With this objective in mind, it is suggested that teachers should be less concerned about the aggressive trouble-makers in their classes and more concerned about those pupils who behave like "little ladies and gentlemen." While this suggestion may, at first glance, appear somewhat strange, it must not be supposed that it is made purely on the basis of some vague and speculative theory. On the contrary, it is based on evidence from a large number of careful studies concerning the earlier childhood characteristics of those persons who later become mentally ill. There is such striking agreement in the results obtained by different investigators that it is neither necessary nor

desirable to undertake a systematic review of the forty or more studies on this question which are reported in the scientific literature. It will be sufficient to summarize briefly the results obtained in a few of these studies as illustrative of the findings in general.

Kasanin and Veo[2] in a very careful and detailed study of the childhood characteristics of eight persons subsequently admitted to mental hospital, found that there was observable evidence of personality disorder long before the presence of a definite mental disease became apparent. In a later study[3] the same investigators examined the school behaviour of fifty-four children who, later in life, became mentally ill. Former teachers of these children were interviewed. It was found that, in the majority of cases, these children had displayed marked peculiarities years before the apparent onset of their illness. When they were in school they had been noticeably shy, backward, and passive. Several of them had been unusually brilliant in their school work.

Mooney and Witmer[4] studied the early person-

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[2]J. Kasanin and L. Veo, "The Early Recognition of Mental Diseases in Children" (*American Journal of Orthopsychiatry*, 1931, I, 406-9).

[3]J. Kasanin and L. Veo, "A Study of the School Adjustments of Children Who Later in Life Became Psychotic" (*American Journal of Orthopsychiatry*, 1932, II, 212).

[4]M. Mooney and H. L. Witmer, "Ten Problem Children Who Later Became Psychotic" (*Smith College Studies in Social Work*, 1932, II, 109-50).

ality development of ten children who were later admitted to mental hospital. They report that in not a single case was there any sudden change in personality just prior to admission to hospital. There was merely an accentuation of habits and characteristics which had been observed previously in school. In every case, they had been markedly seclusive and solitary as children. Eight of the ten cases had displayed violent tempers.

Faver[5] reviewed the life histories available for one hundred and fifty-four mental hospital patients and found that the most frequent characteristics exhibited prior to illness were extreme seclusiveness, "model" behaviour, and irritability.

Lepel[6] in a study of thirty cases was impressed by the large number who had previously been brilliant pupils in school. He also found that, as a group, they had been notably "exclusive," had had few friends and were excessively industrious and ambitious.

One of the most thorough and careful studies on this question is that reported by Bowman.[7] He studied the earlier personality characteristics

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[5]H. E. Faver, "A Study of the Personality in Persons Developing Catatonic Dementia Praecox" (*Psychiatric Quarterly*, 1932, VI, 500-3).

[6]G. F. Lepel, "Schizophrenie bei ehemaligen Musterschulern" (*Zeitschrift für die gesamte Neurologie und Psychiatrie*, 1928, CXII, 575-604).

[7]K. S. Bowman, "Study of the Pre-psychotic Personality in Certain Psychoses" (*American Journal of Orthopsychiatry*, 1934, IV, 473-98).

of a large group of persons who later became mentally ill, but he also studied, in the same way, the earlier history of a large group of persons who did *not* later become mentally ill. This use of a "control" group for purposes of comparison made it possible to determine whether the characteristics observed at an early age among those who later become mentally ill are *distinctive* characteristics. The results obtained by Bowman in this very excellent study confirm in general the findings reported by other observers and justify the conclusion that persons who later develop functional mental illnesses exhibit distinctive personality traits long before there is any evidence of a definite mental disease. The most striking of these characteristics may be briefly summarized as follows:

As children, they are mainly notable for their extreme seclusiveness and reticence. They are characteristically quiet, serious, conscientious, obedient, and well-behaved. They are unusually industrious and often achieve very high standing in their school work. They are inclined to be dependent on adults and show close emotional attachments to parent or teacher. They are relatively inflexible and rigid, finding great difficulty in adjusting to any change in the established routine. They are extremely "touchy" and easily hurt. As they grow older, this childish sensitivity

does not diminish in the normal way but becomes still more exaggerated.

Perhaps the most striking feature of these results is the repeated observation that most persons who later develop a functional mental illness, when they were children in school, were *not* "behaviour problems" in the usual sense of that term. They were *not* the talkative, noisy, careless, obstreperous, independent, misbehaving pupils who cause so much trouble in the classroom. On the contrary, they were usually "model" children and, for that very reason, likely to be overlooked or taken for granted by their teachers.

The results of these studies have been reviewed in some detail in order to indicate the direction in which teachers must look if they are to take an active part in contributing to better mental health in school. It is not suggested that teachers ignore the troublesome child. Actually, there is very little danger of our failing to pay attention to the aggressive, misbehaving pupil. Even if principals and inspectors did not demand it, we would still devote a large measure of our time and effort to him. That is often one of the main reasons why he goes on misbehaving—it is one way of gaining and keeping our attention. On the other hand, it requires something of an effort and a good deal of intelligent understanding for a teacher to provide that quiet assistance which is needed by the

well-behaved but shy, submissive, and solitary pupil who is usually in poorer mental health.

Summary

Those characteristics which teachers regard as most serious in their pupils are actually the least serious from the point of view of mental health. Conversely, those characteristics which teachers regard as least serious—which they tend to ignore or even encourage in their pupils—are actually the most undesirable from the point of view of mental health. Thus, teachers who wish to make a really useful contribution toward the prevention of unnecessary mental illness will shift their attention from the noisy, troublesome "problem" child to the quiet, well-behaved "model" child since it is among the latter that significant mental health problems are likely to be found. It is they who offer us our best opportunity for constructive action directed toward better mental health in school.

. . . IN SCHOOL

INTRODUCTORY COMMENT

What then are the specific indications of poor mental health most frequently displayed by children in school? What causes these indications and what can be done about them? The remainder of our discussion will be devoted to a consideration of these specific and practical classroom problems. Throughout this discussion it will be of the utmost importance to remember that we are dealing with indications of poor mental health in their very earliest stages. It is in the early stages that they can be dealt with most easily and most effectively. This is the only reason for drawing attention to them.

These problems are never in themselves serious. They are merely indications of habits or attitudes which might become serious if they were permitted to develop without intelligent treatment. There is never any justification for alarm or anxiety when a child displays one or more of these "symptoms." All children at one time or another try out these unsatisfactory ways of adjusting to difficulty. All that is required is that the teacher should be able to recognize such symptoms for what they are and quietly, coolly, and intelligently discourage their further development into chronic habits.

VIII

THE "UNSOCIABLE" CHILD

THE "ostrich" method of evading difficulties, which is observed in its most extreme form in certain types of mental illness, is found in milder form among many people who are not mentally ill. While it is probably unfair to ascribe to the ostrich the habit of putting its head in the sand whenever danger threatens, there are certainly humans in whom this method of evasion seems to have become habitual. Such people sometimes become quite expert in "solving" their difficulties by the simple expedient of pretending that there are no difficulties there at all. Resolutely closing their eyes to the facts, they escape into a world of fantasy which, since it is under their own control, can be arranged in such a way as to present no difficulties whatever.

The one thing which prevents most of us from gaining much satisfaction by this means is the fact that our activities bring us into contact with other human beings. Our personal fancies may flourish when we are alone, but they are likely to be rudely shattered by the presence of other people who usually insist that we return to the "real" world which we share with them. In this sense, continued contact with other people ensures, for most of us, continued contact with reality.

Thus, a marked inclination to avoid contact

with one's fellows is often indicative of a developing tendency to employ an "ostrich" method of adjustment. It is the purpose, in this section, to discuss some of the very early indications that a child may be trying out this method of evading difficulties by withdrawing from the real world around him.

Seclusiveness

The seclusive type of child is one who is always wandering off by himself, who prefers to play alone, and who does not show much interest in joining other children in their activities at recess or after school. He is apt to be "bookish" and usually likes nothing better than to stay in and do little chores for the teacher.

Every experienced teacher is familiar with this type of child. Many teachers feel flattered by the evident preference which such a child shows for their company, and by their approval and sympathy definitely encourage the further development of this trend away from the child's own group.

Accordingly, it is well to remember that the seclusive child, no matter how much we like him or how pleasant he is to have around, is developing a habit of social withdrawal which does not provide a good foundation for later mental health.

The very young child, when he has been frustrated or punished, is apt to go off by himself

and pout. As he grows older, this tendency to withdraw whenever he does not get his own way may become more marked. If he learns no more satisfactory way of handling his difficulties, he may come to think that he can have more fun when he is off by himself than he can when there are others around to interfere with his wishes. In extreme cases, this solitary trend serves to isolate him from other children of his own age and make him appear self-centred, close-mouthed, uncommunicative, and secretive.

Unsociable children are not at all uncommon and they certainly must not be regarded as mentally ill. Yet the fact remains that if no one takes the trouble to deal intelligently with this seclusive trend, it may eventually become so extreme as to endanger mental health. What, then, can the teacher do about the seclusive child?

First of all, there are certain things which the wise teacher will *avoid* doing. One of the most common methods of dealing with the seclusive child is to insist that he participate to a larger extent in the social activities of his group. This method is almost certain to exaggerate the difficulty. Making social participation an obligation is one of the surest ways of making the seclusive child still more seclusive. To tell the seclusive child that he *should* go out and play with other children, that he *ought* to enjoy playing with them,

is, of course, entirely beside the point. He already knows this only too well. Making a moral obligation of being sociable simply helps to make it an even more irksome and disagreeable duty than it was before.

Our only chance of helping the seclusive child is to find out *why* he is being seclusive. There is always a reason for seclusiveness and, from the point of view of the child, it is always a good and sufficient reason. Why is he trying to withdraw? Why has social participation become unpleasant and disagreeable for him? Is it because he has found, or thinks he has found, that he cannot compete satisfactorily with other children? Has he never had a chance to learn how to play and does he, therefore, feel uncertain of himself and insecure in his own social group?

We recognize that the ability to spell or add correctly is not instinctive,—that it has to be learned. Sometimes we fail to recognize that, in the same way, the ability to play is not instinctive, —that it has to be learned also. It is most unfortunate for their mental health that some children (and a good many adults) have never *learned* how to play.

The first principle in treatment, then, is to find the cause of the seclusiveness. Having done this we are in a position to take the next and equally important step, that is to make sure that the child

secures some *actual* enjoyment in social activities with other children of his own age. Fortunately this does not have to be done very often. It is a striking fact that a few real demonstrations are far more convincing to the seclusive child than any number of exhortations. Instead of telling him that he *should* have a good time, make certain that, on at least a few occasions, he *does* have a good time.

Preventing seclusiveness. Even better than the proper treatment of the child who is becoming seclusive is the avoidance of those methods of teaching which serve to encourage seclusiveness in our pupils. Thus, whether we know it or not, the classroom in which there is an atmosphere of competitive rivalry is a classroom in which we are definitely encouraging the development of seclusiveness in certain pupils. The reason for this is that in all competitions there are some children who are nearly always losing. Furthermore they are losing, not because they lack incentive nor because they are "refusing to apply themselves," but simply because from the start they have not had a fair chance. It may seem laudably democratic but it is certainly contrary to the facts for teachers to imagine that all men (or pupils) are "born equal."

The manner in which speed competitions serve to encourage seclusiveness may be made apparent

if we take a simple analogy. Let us suppose that we have under our control a group of school teachers. Let us take them out to a recreation field and insist that they run a foot race. Let us keep a careful record of the order in which these school teachers finish the race. Then let us repeat the race every day or, better still, several times a day over a long period of time. Now if we examine the records we will find that, with very few exceptions, the same runners very nearly always win and the same ones nearly always lose. How long do you suppose those teachers who are always losing would keep on enjoying this sort of competitive social activity? How soon would we, by our method, have forced them to try to escape from what must inevitably become a highly disagreeable programme?

By means of our speed competitions in the classroom we sometimes fondly imagine that we are stimulating ambition and effort on the part of our pupils. What we are really doing, however, is stimulating seclusiveness in those who nearly always lose and unwarranted conceit in those who nearly always win. It is difficult to say which effect is the more harmful. Unfortunate is the child who stood first in his classes all through school. He has the difficult task of learning how to adjust himself to the fact that he cannot stand first all through life. Unfortunate, too, is the child

who always loses, but for the chronic loser a way of escape is open. He can simply drop out of the social situation and turn his thoughts and attention inward where there are none of these disagreeable comparisons with his fellows which are so constantly being emphasized in the real world around him.

It must be admitted that there are still some teachers who are so poor at the task of teaching that they simply cannot do anything more with children than act as referees for classroom competitions. However, an increasing number of teachers are discovering that learning can be made so intrinsically interesting that children need no artificial competitions to stimulate their effort.

It is only when the teacher is dull, the subject is dull, and the presentation is dull, that competition is required to whip up the flagging spirits of a disinterested class. It is under these conditions, too, that the teacher, having driven some of the children to escape from a disagreeable world in which they are always losing, is apt to complain most bitterly about pupil-inattention, day-dreaming, and lack of application.

Inattention

To describe an unsatisfactory pupil as inattentive is one of the most naïve habits a teacher can develop. It is naïve because we usually do not

realize that we have thrown a sort of verbal boomerang. There is, of course, no such thing as "inattention." As long as the human organism is alive it is attending—to something. What we really mean when we say that a pupil is inattentive is that he is not paying attention to us, that we have failed to arouse and hold his attention, that we are simply less interesting to him than something else in which he is absorbed.

Of one thing we can always be sure—the "inattentive" child is attending to something. We must remember that he lives in a very complex world in which there are always a great many things competing for his attention. In the classroom, for example, there are lights and sounds and movements, there are many other pupils, there are his own ideas and hopes and memories. There are all these things and many more clamouring for his attention. Consequently, we teachers make a serious mistake if we imagine that we are necessarily the centre of attention simply because we are up at the front of the room making a noise. The fact is that we are only small factors in the hectic competition for pupil attention. Consider our competitors. There is the apple hidden in the desk, the sounds coming in the window, the bent pin to put on a neighbour's seat. There are all the things that happened yesterday and all the things that might happen tomorrow. In such a complex

world the teacher must be prepared to face competition. To expect to win the attention of all of our pupils all of the time is unreasonable and absurd. To compete with moderate success is not impossible but it is a severe test of our ingenuity.

We are wrong if we imagine that we can successfully compete for pupil attention by making ourselves the most disagreeable element in the situation—by being deliberately loud, sharp, shrill, and nasty—by jerking the "inattentive" child unceremoniously back to this real world by the scruff of the neck.

One teacher explained to the writer how she handled the problem of inattention as follows: "I just watch until a child shows the first sign that he is not paying attention. Then, when I am sure that he is off wool-gathering, I come quietly up behind and give him a good sharp rap over the knuckles with a ruler. Believe me, that brings him back to earth in a hurry."

No doubt it does, but it is at least questionable whether the sort of earth he is being brought back to, is very attractive or worth staying in if he can help it.

Another way of trying to deal with inattention is to explain to the child at great length the tremendous and far-reaching importance of his paying close attention to us. This means pointing out as laboriously and painfully as possible the

dreadful consequences of not paying attention. These usually boil down finally to the danger of failing in his school work.

Neither of these methods is either effective or healthy. When we try to deal with the problem in this fashion we are simply treating symptoms. We know that it would be absurd to deal with measles by trying to rub away the red spots on the patient's skin. Inattention is no more than a symptom. We will not get rid of it by drawing attention to it, moralizing over it, or punishing a child for it. Once again intelligent treatment means finding the cause.

Teachers who are honest enough to look for the cause of inattention in their pupils are likely to be embarrassed. The most likely place to find the cause of inattention is not in the pupil at all but in the teacher. When we find that we are failing to compete successfully for a certain pupil's attention, this is a plain fact which needs to be faced squarely. We can, of course, evade the fact and blame the pupil. On the other hand, if we wish to do something constructive about it, we can re-examine and reorganize our methods of teaching in such a way as to give us a better chance of winning the perennial contest for pupil attention.

Day-dreaming

The apparently inattentive child is very often deeply absorbed in a highly enjoyable day-dream. Since many of us become highly incensed when children show that they prefer their own day-dream to anything we may have to offer, it is wise to remember that day-dreaming is a normal and healthy activity in which everyone (even a teacher) indulges to some extent. The fact that many adults seem to have lost the capacity to manufacture their own day-dreams does not mean that they no longer indulge in such activities. They simply go to a bookstore or the theatre and buy their day-dreams ready made. The novel and the play are day-dreams which, for all of us, serve a very useful and healthy purpose. They make available to us a world of imagination which is largely free of the boredom and vexations of the real world. For children, day-dreams have a particularly important function because of the many limitations which are imposed on them by their size and age. Furthermore, as every reader of biography knows, day-dreams often act as a spur to ambition and a stimulus to greater effort. Thus, day-dreaming may be, and usually is, not only a natural and enjoyable but a very wholesome type of activity.

The sort of day-dreaming which teachers object

to is the type which appears to interfere with application to school work. It is, therefore, important to realize that not every child who appears listless and aimless is actually day-dreaming. Conversely, we cannot be sure that the child who appears very busy is *not* day-dreaming. Many children learn that it simply does not pay to take on that blank and vacant expression supposedly characteristic of day-dreaming because the teacher will almost certainly notice it and start to interfere. Some of them find that if they wear a cloak of great industry and simply *appear* to be busy at something they may be permitted to enjoy a good day-dream in peace and comfort.

Once we have made sure that a child is developing the habit of persistent day-dreaming we can be sure that he is a child who is dissatisfied with things as they are and is looking for satisfaction in a world of fantasy. Consequently, it would seem quite evident that the poorest possible way of dealing with the difficulty is to scold or nag or punish. It is the disagreeableness of his real world that is leading the child to attempt an escape into day-dreams in the first place. Making the real world still more disagreeable can hardly be regarded as intelligent treatment.

When chronic day-dreaming threatens to interfere with necessary activity in the real world, there is good reason to help the child to get rid of an

inefficient habit. Fortunately, even the most persistent day-dreamer is not difficult to treat successfully if a few simple principles are kept in mind.

1. *Find the cause.* Why is the child day-dreaming? Has he lost interest in the real world around him because it presents to him difficulties and because he is always failing when he attempts to deal with them? Has he lost interest because things are too easy, have become monotonous, and offer no real challenge to his ability? In order to find the cause, it is usually necessary to:

2. *Discover what the day-dreaming is about.* This is sometimes a difficult matter. When very young, children are quite willing to talk about their day-dreams. They soon find, however, that many adults do not seem to approve of day-dreams and either regard them as foolish nonsense or take the absurd position that the child is telling lies. If we wish to help the chronic day-dreamer, we must rid ourselves of this false adult attitude of superiority toward day-dreams. We must gain the child's confidence before we can find out what he is day-dreaming about.

There are two main types of day-dreamer. There is the casual type, through whose day-dreaming there runs no very consistent theme or motive. Once we have found that the day-dreaming is of this type, we need feel no concern about

the problem. Given a reasonably stimulating environment it will not seriously interfere with either health or efficiency.

It is the systematic type of day-dreamer who really needs our help. He is the child whose fantasies persistently follow a central theme. This may be a "conquering hero" theme. Having failed to make a place on the school team, he pictures himself as the captain who, in the dying moments of the game, achieves some daring feat of amazing courage and skill and so wins the contest amid the plaudits of an admiring throng. On the other hand, it may be a "suffering hero" theme. After what he regards as unjust treatment at home or at school, he pictures himself running away, joining a gang of thieves and criminals, robbing a bank, and perhaps finally lying mortally wounded while his teacher or parents weep over him and beg forgiveness for having treated him so unfairly.

Day-dreaming which tends to follow some such systematic theme indicates clearly the type of emotional difficulty which is at the root of the trouble. Having gained some insight as to the nature of the day-dreaming and, therefore, the cause of the symptoms, we can proceed with treatment along the following lines.

3. *See that day-dreams lead to activity.* It is quite harmless for the small boy to dream about being captain of the team and winning the game,

or for the small girl to dream she is the centre of a circle of admiring friends, if these dreams serve as a spur to activity—if they lead the boy to practise on the playing field and the girl to cultivate her friends. It is only when day-dreams become a substitute for actually doing anything about the difficulty that they tend to become unhealthy. See that the day-dreamer makes constructive use of his day-dreams. Day-dreams serve a useful function when they are harnessed to activity. In this way they can be transformed from a potential enemy into a valuable ally.

4. *Ensure some real achievement.* One good taste of a *real* success makes all our imaginary victories pale and insipid. The chronic day-dreamer who is given a chance to experience some real satisfaction will soon abandon the world of fantasy in which his satisfactions were purely imaginary.

Shyness

The unsociable child is often described as a shy, self-conscious child. Usually we do not regard him as a serious problem. In fact many teachers and parents are inclined to encourage these characteristics because they are supposed to reflect a proper modesty. Such a child causes no trouble in the classroom and is apt to receive a good deal of approval on that account alone.

Self-consciousness, whether in a child or in an adult, is never due to modesty. As a matter of fact, it is caused by the very opposite of modesty. It is evidence of an entirely unwarranted conceit. The self-conscious person is so preoccupied with himself that he imagines he is the object of everyone else's attention. This obviously indicates a false notion of one's own importance.

Our usual methods of treating shyness and self-consciousness seem cleverly designed to exaggerate this false conceit. The sympathy and solicitude we often show for such a child *do* make him the object of everyone's attention. Similarly, many of the activities (such as oral compositions) into which we force him and which are supposed to add to his self-confidence actually *do* make him the centre of attention. For children who are not shy, such activities frequently give a confidence they do not need. For the shy child such activities usually exaggerate his self-consciousness.

The shy, self-conscious child needs help in developing a proper perspective in regard to his own importance. He needs assistance to realize that he is only one member of a large group and not such a very important member at that. He needs to learn that he is *not* the object of everyone's interest and attention. He needs to participate in activities which make him feel that he is *part* of the group rather than in activities which place him

up in *front* of the group. It is only when he has learned to feel comfortable *in* and *with* the group that he can gain confidence to perform satisfactorily *before* the group.

IX

THE "MODEL" CHILD

IT will be recalled that in studying the earlier characteristics of people who later become mentally ill, it was found that a large number of them had displayed as children characteristics which are commonly regarded as virtues. When they were pupils in school their teachers had observed that they were not only quiet and well-behaved but that in most respects their deportment was so exemplary as to justify their being called "model" children.

The results of these studies suggest that there are certain virtues, which although desirable within limits, may be carried to such an extreme that they become symptomatic of poor mental health. Few will deny that the excessive display of almost any virtue is apt to become a vice. However, the difficult problem is to determine just when an otherwise desirable virtue is becoming excessive. As far as mental health is concerned, it can be said generally that any virtue is excessive when it becomes a means of evading difficulties. The manner in which certain virtues may serve this purpose in the classroom will be illustrated briefly.

Neatness

In some classrooms the habit of being neat and tidy is raised by the teacher to the level of a major

virtue. The very nature of the teacher's task often serves to exaggerate the apparent importance of this characteristic in the classroom. The pedantry of the pedagogue has long been the object of ridicule among "practical" people and there is little doubt that anxiety over the dotting of i's and the crossing of t's can be carried too far if we are at all concerned about the ultimate effects of our teaching on the personality of our pupils. It so happens that meticulous concern over unimportant details is not shown by people who are in good mental and emotional health. Healthy and efficient persons are not, as a general rule, extremely neat and tidy in their habits. Whenever teachers feel unduly exercised about untidiness in their pupils, it is a healthy restorative for them to go home and examine the disorder which, (if they are healthy) they will almost certainly find in their own bureau.

No one will seriously question the fact that pupils need to learn how to be reasonably tidy and neat in their work. The difficult question is: "What is reasonable?" It must be granted that the task of deciding what is really important and what is after all an unimportant detail is no easy matter. However, there are some teachers who act as though they regarded neatness in and for itself as the major purpose in their teaching. They lavish upon it a degree of praise and approval

which is out of all proportion to its ultimate importance. Thus, the excessively neat child is often one who, having failed at other and more important things, finds that he can get the approval he craves by simply being neat and tidy. Under such circumstances an otherwise desirable characteristic becomes a method of evasion which should not be encouraged.

Conscientiousness

Probably no pupil so much delights the heart of a teacher as the conscientious child. Being serious-minded, he takes both us and the work we give him seriously. He is industrious, ambitious, and earnest. To him school work is a serious matter. It is natural that teachers should approve such a laudable if relatively uncommon attitude.

Yet the child who shows great anxiety over mistakes and marked distress at failure is not developing a healthy set of emotional habits. It is all very well to be somewhat concerned when we have failed but none of us can afford to be unduly disturbed about it. Failure is inevitable and universal. All of us fail on occasion and if we are to preserve our mental balance we must know how to fail without getting too much upset over it.

One of the most important and difficult things which our pupils need to learn is how to fail gracefully. They need our assistance in learning how to take their failure in a healthy and not

unduly emotional fashion. The extremely conscientious child is not learning how to do this. He is frightened by the possibility of failure. This may be because he has an unwarranted fear of punishment and ridicule.

Most teachers are reluctant to penalize any child who gives the appearance of having made a conscientious effort. Some children learn to make use of this fact in escaping the natural consequences of their failure and inefficiency. No child should be encouraged to substitute an air of conscientious concern in place of honest effort.

Courtesy

The dangers inherent in the praise we give to a polite and deferential child should be evident. The child who does not do his work very well but who is courteous and mannerly is apt to discover that after all he does not need to do his work very well. Despite his inefficiency or lack of effort his politeness "gets him by." When the excessive display of any virtue permits a child to escape from the consequences of his behaviour, it is not conducive to the development of good mental health.

Honesty

The child who makes a great fuss about being honest, about returning lost objects to their owners,

about reporting the misdemeanours of other pupils, is a child who deserves our attention. He usually turns out to be a child who is suffering from an unsatisfied craving for praise, and who is using this indirect means of securing it.

It is really surprising that we make such a fuss about this kind of honesty. Honest and straightforward conduct should be accepted surely as the normal and natural way of behaving. No child should be led to think that he is doing something extraordinarily praiseworthy when he is simply being honest. When he grows up he will be disappointed. No one is likely to take the trouble to praise him highly for behaving in a properly civilized manner. It is unhealthy for him to develop the habit of expecting praise for normal socialized behaviour.

When honesty along certain lines is displayed in a very blatant fashion, it is often found to be an attempt to cover up dishonesty along other lines. Investigation has shown that character traits like honesty and neatness are not general characteristics and actually show little transfer from one situation to another. A child may be very honest with one teacher and very dishonest with another. He may be honest in writing examinations and dishonest in playing hockey. It appears that honesty needs to be learned in respect to specific situations and activities. Thus,

we should at least realize that an appearance of excessive honesty in regard to unimportant matters is not reliable evidence of honesty in respect to other more important matters.

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There are many other classroom virtues which become unhealthy if they are shown to excess. Industry, ambition, caution, and thrift might be discussed from the same point of view. However, it is probably unnecessary to elaborate further on the desirability of re-examining our standards of deportment in the classroom. All that is needed is that we make sure they are reasonable standards (that is, reasonable for our pupils) and then avoid making a fuss about them. Usually when we praise the "good" child for living up to our standards, we have our eye on the "bad" child and hope that this praise will influence him. Of course it does influence him,—but practically never in the direction we intend. We would do well to turn our attention back to the "good" child and remember that such excessive praise may not be having a very healthy effect on him.

We have a very potent means for controlling children's behaviour which is inadequately used. This is the method of showing confident expectation. If we show a pupil that we expect the worst of him, he will certainly do his best not to disappoint us. The same is true of expecting the best

from a pupil and showing that we expect it. Those teachers are wise who show that they confidently expect conformity to reasonable standards of behaviour and avoid giving undue praise to a display of excessive virtue which may be merely a smoke-screen behind which an inefficient pupil is trying to hide.

X

THE "DEFENSIVE" CHILD

ONE of the characteristics of those suffering from certain mental illnesses is the twisted type of thinking which they employ as a defense against reality. Among the mentally ill this defensive type of thinking is seen in its most extreme form. In mild form it is almost universal. The task of learning to do our thinking in a straightforward and logical fashion is one in which none of us ever achieves perfection. To some extent we all tend to twist our thinking to suit our purposes. Certain types of defensive evasion are very commonly observed among children in school and it is to these that we now turn our attention.

Rationalizing

Rationalizing is a distorted form of thinking that superficially looks like reasoning. It consists in giving elaborate and logical-sounding reasons to explain an act which was really performed for purely emotional reasons. The man who buys himself a new car which he does not need and cannot afford may proceed to give us a very large number of complicated reasons for his behaviour. He may tell us that he bought it in order to take his wife and children on trips to the country or that an impressive automobile has become for him a business necessity. These may or may not be

valid explanations of his behaviour. If he really bought it simply because he wanted a new car, then these are rationalizations.

A teacher has lessons to prepare or other work which must be ready for the next day. A friend proposes an excursion which sounds attractive. This creates a dilemma. The teacher being a healthy person decides to go on the excursion. That is fine. But now the rationalizing begins. The teacher "explains" that a person must not try to work all of the time, that anyone who does is likely to become "stale," that all work and no play is bad for a person. In fact the more the teacher thinks about it the more "reasons" there are for going on the excursion. Many of these reasons will sound very plausible especially to the person who is giving them. The important point is that they are not the real reasons for the behaviour.

It is a curious fact that in rationalizing we very often fool ourselves without misleading anyone else. It is seldom difficult to see that someone else is rationalizing. It is very difficult to see that our own thinking is becoming a little twisted. Consequently in dealing with the rationalizing of children it is first of all important that we develop a somewhat tolerant attitude. Children show an early aptitude for rationalizing. They learn rapidly that this is one of the simplest and most

useful methods of self-justification and fact-dodging. One reason for the rapid development of this habit in children is that parents and teachers constantly set for them such excellent examples of twisted thinking.

Another reason is that parents and teachers place such a high premium on good excuses. It is natural that children should discover the tremendous importance of becoming quick with plausible alibis. A good excuse is a useful thing, not only in court but in any setting in which people spend most of their time in looking for culprits. Unfortunately, there are some homes and classrooms in which this sort of atmosphere prevails.

Teachers who would deal intelligently with rationalization in the classroom must first gain an insight into their own use of this method. They are wise teachers who know their own rationalizations. Children do their rationalizing in a very obvious way. Thus, we see through their "explanations" very easily and are apt to be quite superior and sarcastic about them. While there is a value in showing that we have not been misled by the rationalizing, there is also value in showing that we are reasonably tolerant about such defensive devices. Instead of taking too much delight in exploding a child's feeble attempts, we do better to indicate that such efforts at evasion, althoug

mildly amusing, are neither very useful nor very important. Certainly to take the attitude that they are deliberate lies is to show that we have tragically little understanding. Teachers who have sufficient sense of humour to recognize that they rationalize themselves are not likely to get unduly excited about this problem when it occurs in children. That it is undesirable is evident. That it is to some degree universal is equally important.

Alibis

One of the most common forms of twisted thinking is the habit of justifying yourself by placing the blame on someone else. Like other forms of rationalizing the habit of blaming others is most likely to develop in an atmosphere in which great emphasis is placed on finding the culprit and placing the blame. In any classroom where the teacher spends much of the time fixing responsibility for misdemeanours, bright pupils will learn that the thing to do is to blame someone else as quickly as possible.

Teachers who are not always on the look-out for someone to blame, who discourage the use of alibis and the habit of "tattling," but who develop in the classroom a social code which involves "facing the music," accepting the consequences of one's own behaviour, and even on occasion accepting the consequences of the behaviour of one's

colleagues, are thereby encouraging straightforward thinking and unevasive behaviour and making an important contribution to sound mental and emotional health among pupils.

Bragging

Some children attempt to escape from their present difficulties and failures by reverting to childish and infantile forms of behaviour. One form of this evasion is shown by the child who does a great deal of bragging about his past exploits. The braggart is a difficult child to handle. Teachers dislike such childish conceit and sometimes take keen enjoyment in deflating it.

However, the extent to which we take pleasure in pricking the balloon of a bragging child is a direct measure of our own ignorance. The fact is that a bragging child is nearly always an insecure child who feels inferior and uncertain about his own ability. Thus, in "taking him down" we add to his insecurity and force him to exaggerate still more his outward appearance of self-confidence.

A quiet recognition of the source of the child's difficulty and a sincere effort to help him learn how to handle his difficulties in the present situation usually make it unnecessary for him to bolster up his confidence by exaggerating his past exploits. The child who brags about his past is usually doing so because he is not able to succeed

in the present. Constructive treatment, therefore, means an effort to develop in him a greater sense of security and a confidence that he can handle his present problems with reasonable satisfaction and success.

XI

THE "NERVOUS" CHILD

THERE are few if any terms in popular use today which are more unsatisfactory, and even misleading, than the adjective "nervous." There are several reasons for this. In the first place, it is an extremely vague descriptive term which most people think they understand but which no one bothers to define. In practice, it is used in connection with such a wide variety of different symptoms and characteristics that its value may be seriously questioned.

Sometimes, when we call a person "nervous," we mean that he is timid, fearful, and anxious; sometimes we mean that he is shy, awkward, and socially ill at ease; sometimes we mean that he behaves in a childish and immature fashion; sometimes we mean that he is irritable, tense, and over-active. Thus to say that a person is "nervous" may imply a great deal but actually tells us nothing about the nature of the problem he presents. If we mean that one child is timid and that another child is over-active, it is obviously better to say so in plain and simple language. To call both of them "nervous" certainly adds nothing to our understanding of such children.

A second and more serious objection to the term "nervous" is that we so often use it as though it were an explanation. When we have described

the difficult child as "nervous," we are apt to imagine that we have thrown some light on the source of the difficulty. It is as though we said: "This child has been born with a special sort of nervous system which is extremely delicate or sensitive. That is *why* he is so difficult to handle. There isn't anything that can be done about it. We must simply handle him carefully and see that not too much is demanded of him."

This makes a pretty story—especially when told to the teacher by a fond and over-solicitous parent. Yet the fact is that most children who are described as "nervous" have a perfectly normal nervous system. There is nothing whatever wrong with their nerves.[1] There usually *is* something wrong with their training.

Many parents seem almost proud of having a "nervous" child. They give the impression that they regard this as a mark of distinction—an indication of good breeding. Nothing, of course, could be further from the truth. The plain fact is that "nervousness" in humans has nothing whatever to do with the tense and "high-strung" characteristics supposedly shown by thoroughbred horses.

It is true that, in terms of their psychological

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[1]The extraordinary lengths to which our misinformation concerning the nervous system may carry us is illustrated by the mother who protested so earnestly to a friend: "But, my dear, don't you know you should never spank a child because if you do you are in danger of injuring the *seat* of the nervous system."

characteristics, all men are not "born equal." We have emphasized above the wide differences in general ability or intelligence which appear to be native and largely fixed at birth. It is probable that there are other in-born constitutional differences in respect to such characteristics as temperament and nervous irritability, although much less is definitely known about these. Yet the fact remains that what is commonly described as "nervousness" has nothing to do with the state of a person's nerves and is not primarily a matter of inherited constitutional make-up. It *is* usually a matter of acquiring undesirable habits of emotional expression. That "nervous" parents tend to have "nervous" children proves nothing, of course, except that bad habits are apt to spread—especially to one's own children.

The proper treatment of the "nervous" child in school presents special difficulties. The main principle in such treatment can be simply stated: Treat the "nervous" child as a *normal* child. But this is not easy to do. He *is* a perfectly normal ordinary child but he does not think so. He feels insecure and uncertain. He believes he is "different." The chances are that he has been told by his parents or has heard others say that he is a "nervous" child. He may have learned that he can secure special consideration because of his "nervousness." In many cases, his problems

really originate in the fact that he knows other people regard him as "nervous."

Our main task, then, is to help him get rid of the notion that he is odd, peculiar, different, or for any other reason, worthy of special consideration. This does not mean going out of our way to be abrupt or harsh with him. Yet to give such a child much in the way of sympathy simply increases his sense of insecurity and dependence. Offering such a child lengthy explanations as to why he should not feel nervous simply confirms his opinion that he is different. Forcing him into the limelight simply adds to his embarrassment. His only chance of discovering that he *is* a normal child will come when others actually *treat* him as a normal child.

With this general principle of treatment in mind, it is proposed in this and the following section on the "emotional" child, to examine some of the specific problems which are commonly encountered in dealing with so-called "nervous" children.

Nervous Tics

Many children develop little mannerisms or habit-spasms which they repeat in a mechanical, stereotyped form and which are known as "tics." Every experienced teacher is familiar with the many different forms these may take and knows how troublesome they may become in the class-

room. They include such types of behaviour as, grimacing, twitching, jerking, nail-biting, lip-pulling, shrugging, nodding, blinking, twisting, picking, scratching, throat-clearing, and coughing. It is probable that these mannerisms were originally useful in giving relief from some local irritation, but when they persist in the form of stereotyped habits they serve no apparent purpose (except perhaps to annoy the teacher).

It is a common mistake to suppose that a nervous mannerism is a deliberate, voluntary movement fully under the control of the person showing it. Such is not the case. Once it has become habitual, the person not only has the greatest difficulty controlling it but often is not even aware that he is displaying any mannerism at all.

Thus teachers who find the tics of their pupils annoying have a difficult and somewhat embarrassing first step to take. This is to discover what their own tics are. Of one thing we can be quite sure—we all have certain mannerisms of which we are totally unaware and which our friends are tactful enough to ignore. In one study,[2] pupils were asked to list the things which annoyed them most about their teachers and, mentioned most frequently, were: twisting the mouth into odd

[2]S. P. Hayes, "Am I a Good Teacher?" (*Teachers' Forum* (*Blind*), 1935, IX, 33).

shapes, frowning, playing with chalk, cocking head, pulling at ears, nose, or lips, scratching head, not looking at class, habits of posture. "Let him that is without tics, cast the first stone."

It seems likely that if we were more aware of our own mannerisms, we would waste less time exhorting, moralizing, threatening, or punishing pupils for theirs. For one thing, we would realize more clearly that they are difficult habits to control and that if our attention is being constantly called to them our difficulties are apt to increase rather than diminish. Perhaps, too, we might begin to see that they are not of such vital importance as we had supposed.

At any rate, it is the height of futility to try to insist that a child deliberately eliminate a nervous mannerism. Such a method nearly always makes the mannerism worse. Many of these activities never would have become mannerisms at all if they had been ignored in the first place. Drawing the child's attention to them, scolding nagging, and punishing, not only serve to exaggerate their importance but positively encourage their persistence.

Nervous tics should not be permitted to loom as matters of great importance either in the mind of the teacher or in the mind of the pupil. Most of these tics are not nearly as important as we suppose. Natural social pressure from his fellow

pupils serves to eliminate most of the school child's undesirable tics without undue difficulty. Meanwhile, teachers need do little more about them than provide a rich programme of distracting activity, plenty of gross muscular exercise, and sufficient in the way of hand work to ensure the purposeful use of available energy.

Exaggerating Illness

One of the neurotic devices commonly employed by both children and adults in an effort to evade their difficulties is to exaggerate minor pains and illnesses. Children do this in a very obvious and transparent fashion. They have not yet learned to be as clever at it as most adults eventually become. Hence our usual method of dealing with the child who tries to use aches and pains and illnesses for such a purpose, is to be very severe with him. We see through his pretence so easily that we take delight in proving that it is only a pretence, that he is not really ill,—and therefore sternly withhold the sympathy we would otherwise feel.

It should be evident, however, that the child who shows a persistent tendency to exaggerate his illnesses is doing so for a purpose. That purpose is usually to secure sympathy and attention. Withholding sympathy and attention from such a child because we think he is pretending, simply

means that he must exaggerate his illness still more. He must do something to convince us. There are some children who, if we remain stern and severe long enough, can manage to make themselves physically ill. In this way, they finally throttle the sympathy and attention out of us whether we like it or not.

In dealing with the child who is exaggerating illness, it is well to remember that, rightly or wrongly, he believes he is not receiving the sympathy and attention to which he is entitled. It is not necessary, of course, to hand out sympathy just because he wants it. It *is* necessary, however, to find out why he thinks he is entitled to more sympathy than he is getting. Intelligent treatment means making sure that such a child receives a reasonable amount of sympathy and attention at other times so that he will not have to pretend illness in order to extract it by force.

XII

THE "EMOTIONAL" CHILD

MOST of the children commonly called "nervous" might more accurately be described as "emotionally unstable." Accordingly, we turn now to a brief consideration of certain aspects of emotional hygiene.

It is only gradually that we have come to recognize that emotional habits constitute the essential foundation for good mental health. There has been so much talk about intelligence, one would almost think that there was nothing about a person more important than the level of his intellectual ability. There is. The characteristics of a person which are most important in determining his success, his happiness, and his health are the emotional characteristics to which, until recently, relatively little attention has been paid.

Our emotional equipment, as we have it in adulthood, is almost wholly acquired. We were not born with it. In large measure, what we are emotionally is the product of learning. Thus, it becomes important that we have some understanding of the manner in which this learning takes place.

The human infant starts out in life with an emotional equipment which is amazingly limited. There are, to begin with, none of those supposedly "natural" or "instinctive" fears (such as fear of

the dark, of water, of slimy animals, etc.) which are later found among so many children and adults. There are actually only a very small number of specific stimuli which are originally effective in producing an emotion (a sudden loud sound, sudden loss of support, direct bodily injury, interference with breathing, restriction of movement).

Yet, by the time a child comes to us at school he has become susceptible to a vast array of stimuli which are now capable of arousing strong emotion in him. How has this change come about? Experiments have shown how artificial fears can be easily and rapidly established in the growing infant. For instance, Peter, a one-year-old boy, was made intensely afraid of his pet white rabbit by simply presenting the rabbit to him and at the same time applying one of the original emotion-causing stimuli—in this case, a sudden loud sound. After a few simultaneous presentations of the rabbit and the loud sound, Peter showed great fear of the rabbit even when it was presented alone.

It has been found that such artificial fears are easily established; that once established they tend to spread rapidly to other similar objects and situations; and that they tend to persist over long periods of time unless carefully and deliberately eradicated. Thus it is that the child who starts out with only a few emotion-causing stimuli, comes

to us at school with a whole repertoire of foolish and unnecessary fears which appear to have no sensible basis.

On the side of expression, our native in-born emotional equipment is also very limited. There are apparently no "natural" or "instinctive" ways of expressing different emotions. At first, the infant expresses emotion by random, diffuse, massive movements involving the whole body. Only later does he learn to express different emotions in different specific ways.[1]

One of the most difficult tasks which the growing child has to face is the problem of learning how to express his emotions in a socially acceptable manner. At first, he expresses anger by violent thrashing, kicking, biting, screaming, etc., but society disapproves of this sort of behaviour. Slowly, he learns more effective methods of fighting—wrestling, punching, hair-pulling—but society does not approve of these either. He then learns how to substitute smaller movements such as gestures—shaking fist, scowling—but even these are not "refined" enough to suit parents and teachers. Even if he manages to refine his expression of anger to the point where he uses only the

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[1]Incidentally, this is one reason why teachers need to exercise great caution in interpreting emotional expression in their pupils. What is really fear may easily be mistaken for anger or defiance or impertinence, and very unsatisfactorily handled because of such misinterpretation.

speech mechanism, this is not sufficient. Society demands that he learn to repress all outward expression of emotion.

As an infant, he expressed anger violently and with his whole body. As a properly socialized adult, he must not show his anger by so much as the flicker of an eyelid. This process of refinement creates a serious health problem since the repression of the outward expression of an emotion does not do away with the important and widespread internal organic changes which always accompany it. Investigators have shown that during strong emotion, most of the ordinary vegetative functions of the organism are disrupted, normal digestive activities cease, gastric secretions are much reduced, circulation is speeded up, additional reserves of sugar are supplied as fuel to the muscles, the blood chemistry is altered so as to facilitate clotting in case of wounds, and, in general, all the resources of the organism are mobilized to meet an emergency.

These internal organic changes, of course, are not under our voluntary control. They take place just the same whether we manage to repress the outward expression of our emotion or not. And it is precisely these organic changes which make emotion an important health problem in our modern world.

Originally, emotions must have had great

biological value. Under primitive conditions, the additional supply of muscular energy would have obvious survival value in meeting an emergency. But what about our modern world? In how many of the situations where we become highly emotional, does an increase in gross muscular strength really help us? In most such situations, society demands that we should not use our muscles at all. We must be "refined" and retain our social poise. We mustn't *do* anything to use up this extra energy which has been generated. Dr. Crile, one of the outstanding physiologists on this continent, has suggested that the person who is constantly emotional is very much like a motor car left standing at the curb with the engine running full speed. When we attempt to repress a violent emotion our "motor" is generating a great deal of excess energy while we try to stand still and appear outwardly calm and collected.

The answer to this problem is not a simple one. To suggest that "children should not be taught to repress their emotions" is patently absurd. It is perfectly evident that we could not have a civilized society if everyone felt free to express his emotions as he chose. If we gave full vent to our emotions every time our toes were stepped on in a theatre or someone bumped against us in a street car, it would be impossible to have theatres or street cars. The very nature of our social organization demands

control of emotional expression. When emotions gain free expression on an international scale we have the social chaos of war. Thus, training in the control of emotional expression and its repression into channels of behaviour which are socially acceptable is a vitally important aspect of child education.

Yet the fact remains that emotions, whether repressed or not, are accompanied by widespread organic disturbances which have important effects on our physical and mental health. It appears, therefore, that what we need in our modern world is not less repression of emotional expression, but less superfluous emotion.

The world in which we live today is filled with a vast number of things about which we have learned to become emotional. The individual is constantly exposed through press and radio to things which make him angry or things which make him afraid. It has become trite to remark on the way in which modern inventions have broken down the barriers of space and time. But it is not so frequently noticed that this process has exposed us to a continual bombardment of emotional-causing stimuli from which our ancestors were comparatively free. When news took months to arrive, there was little point in becoming emotionally upset about remote events. Now actual and threatened calamities no longer keep

their distance. International crises, dangerous clashes, threatening events which occur on the other side of the world one evening are served to us with our breakfast coffee the next morning,—if, indeed, we missed them on the radio the night they happened.

There is, of course, no good purpose to be served by complaining about this characteristic of our modern world. Most healthy people develop a protective resistance against these attacks on their stability. Yet it is important that we learn how to insulate both ourselves and children against unnecessary emotional strain. Certainly, if good physical and mental health is a legitimate objective in education, we must find some way to reduce the amount of superfluous emotionalizing that is done in our schools.

Teachers are often inclined to regard the emotion of fear as an important ally in motivating children. It is often used deliberately as an incentive—a stimulus to greater effort or a means of controlling behaviour. When we use fear of punishment as a deterrent, we should at least know what we are doing. We should realize that, among other things, we are producing in the child a type of organic disturbance which, if prolonged, will be harmful to health. We should also know that constant or intense emotional upset has a detrimental effect on efficiency. Routine activities

and skills are disrupted by the presence of a strong emotion. The presence of fear, in any marked degree, inevitably interferes with efficiency in learning. Thus, we do well to examine carefully the apparently easy results we seem to obtain by the use of fear as an incentive.

Leaving the general problem of emotional hygiene, we turn now to certain of the specific symptoms of emotional strain in school children.

Timidity

Our first concern is with the timid child—the child who has developed so many fears that he is almost always afraid, has no confidence in himself or others, and shows great anxiety about trying anything new or strange. Such a child often gives many indirect signs of his poor emotional health. Disturbances of sleep and digestion are particularly common. Night-terrors, inability to go to sleep, restlessness, lack of appetite, food-fussiness, and a general appearance of malnutrition in spite of an adequate diet are frequently indicators of chronic timidity.

The causes of timidity are many. Most of our timid children became timid long before they arrived at school. They were timidly handled at home and they came to school with an anxiety habit well supported by a large number of irrational and unnecessary fears. However, the fact that the

initial causes of timidity are usually to be found in the home, does not absolve the teacher from all responsibility in the matter. The timid child can either be relieved of his burden of anxiety by what happens to him at school or he can be made still more timid.

For example, his timidity will certainly be increased if he has the misfortune to fall into the hands of one of those teachers who takes pride in being an "iron disciplinarian." (Such teachers may succeed in keeping order but they also succeed in making cowards of some of their pupils.) Another way to add to the emotional strain of the timid child is to maintain a highly competitive atmosphere in the classroom. Lack of ability in the child is sometimes a cause of timidity. When limited ability on the part of the child comes in conflict with unlimited ambitions on the part of parents and teachers, something has to break and it is usually the child who breaks emotionally. Another frequent causal factor producing timidity in school is social starvation. The child who is excluded from the social group, who is different (or thinks he is different) from other children is sure to be under heavy emotional strain.

Someone has suggested that there are three main principles to employ in the treatment of the timid child: "The first is tact. The second is tact. And the third is tact." The intelligent treatment

of the timid child is certainly one of the teacher's most difficult tasks. On the one hand, we must avoid an abrupt and startling manner which will only add to his timidity. On the other hand, we must also avoid a sympathetic and protective manner. To show any concern over him, serves immediately to confirm his worst fears and suspicions. It is essential that we adopt and maintain a quiet but casual and offhand manner with the timid child, treating him no differently than we do other children, showing clearly that we are not worried about him and that, as far as we can see, there is no reason why he should be worried about himself.

Specific Fears

The child who shows a specific and very intense fear of some particular object or situation presents special difficulties in treatment. These fears are often due to some minor accident in the child's past experience, the details of which have long since been forgotten. Only the fear remains, but the fact that it seems to have no reasonable or logical basis makes it no less real to the child.

In attempting to deal with these specific fears, it is important to remember that they are nearly always irrational (or non-rational) in origin. Hence, there is little to be gained by reasoning with the child about his fear. Lengthy discussions on the subject, explanations, and arguments are

quite futile because they are irrelevant. Even adults who are afraid of electric storms know full well that the mathematical chances of their being struck by lightning are low. Such fears do not develop on the basis of logical reasoning, and logical reasoning has little or no effect in removing them.

It may be useful in this connection to report briefly what happened when an attempt was made to get rid of the artificial fears which had been experimentally induced in a group of pre-school children. The instance of Peter's fear of the white rabbit, described above, will be used here for purposes of illustration. Nearly all of the common methods of dealing with children's fears were tried out and nearly all of them failed. For instance:

Reasoning: "Now, Peter, there is nothing to be afraid of. This is your nice Bunny. He won't hurt you. Look, I can put my fingers right in his mouth and he doesn't bite." This was all very well and Peter listened attentively, but it had no effect whatever on his fear.

Information: A course of study was undertaken as a result of which Peter got to know just about all there was to know about rabbits (in theory) but when the actual rabbit appeared on the scene he was just as frightened as ever. Even being a "rabbit expert" didn't help.

Forcing: "This is just a lot of silly nonsense. Push the rabbit in his face. Make him live with rabbits. He'll get over it." (If he's afraid of the water, just throw him right in—he'll get over it!") This method had to be discontinued because of the continued paroxysms of fear it produced.

Ridicule: "Little sissy. Imagine being afraid of a harmless Bunny. I'm ashamed of you. Come on now, try to be a little man." No results.

Disuse: "Leave him alone. Keep him away from rabbits for a while until he forgets about them. He'll grow out of it." Peter didn't forget it and he didn't "grow out of it."

It was found in these experiments that the most effective method of treating irrational fears in Peter and his fellow subjects was social example. However, the social example had to be provided by other children of Peter's own age, not by adults. The only observation that seemed to carry any real weight with him was the discovery that other children of his own age were not afraid of the rabbit. Even then, recovery was a gradual process. At first, he would leave the group of children as soon as the rabbit appeared, but if no attention was paid to him, he would slowly circle around until finally he was able to join the group again and play as freely with the rabbit as the others were doing.

Another method which proved effective was the deliberate and gradual establishment of a favourable association. Peter had been made afraid of the rabbit because of its association with a sudden loud sound which was very frightening. But Peter was very fond of his meals. Accordingly, the rabbit (safely tethered) was very slowly introduced into the room where Peter had his meals.

Day by day, it was allowed a little closer. Gradually, it became associated with something Peter liked rather than with something that he feared. This method required a great deal of patience but proved effective if employed with sufficient care.

Inferiority

The phrase "inferiority complex" became so popular several years ago that nearly everyone seemed to think he ought to have one. Perhaps this is one reason why the phrase is in such disrepute at the present time. A more important reason, however, is that when we say a person is suffering from an "inferiority complex" we imply that he always feels inferior in all situations. Actually there is no such person. Even in the most extreme case, careful observation will show that inferiority attitudes have developed in respect to certain situations and types of activity, but that there are other spheres of activity in which the person does not feel inferior at all. The importance of this is that the problem of treatment is not one of dealing with an inferiority attitude *in general*, but is one of correcting *specific* inferiority attitudes in regard to specific situations.

Certain children develop a marked inferiority attitude toward the school situation. This is more often caused by social ostracism than by difficulty with school work. Such children are often found

to believe that they are different from the other children. This belief may or may not be well-founded but special handicaps or peculiarities sometimes provide the basis for such a notion. Children with heavy-lens glasses, cross-eyes, prominent dental bands, or other disfiguring peculiarities are apt to develop inferiority feelings. Many such children are being helped to achieve the confidence and emotional maturity they need by teachers who do not offer consolation but who treat them as normal children and insist that others treat them as normal.

Stuttering

Why mention stuttering in a discussion of the "emotional" child? Simply because, in most cases, stuttering is a symptom of emotional difficulty. The proportion of stutterers who have any structural organic defect of the language mechanism is very small. Obviously, this possibility should be ruled out by careful medical examination before any other treatment is attempted. In the vast majority of cases, however, stuttering is essentially an emotional problem. This is reflected by the fact that most stutterers are much worse in certain situations than in others. It has been said with some truth that the stutterer "can always sing, swear and soliloquize."

In most cases of stuttering, very little benefit

is obtained by concentrating on speech exercises, breath control, and the usual paraphernalia of "speech training." In some cases, formal speech exercises actually increase the difficulty. They serve to convince the stutterer that he is peculiar and thus increase the emotional tension which is really responsible for the speech defect.

When the stuttering is severe and of long standing, it is well to realize that successful treatment may require the services of someone who has had special training in this work. Treatment, to be effective, must be directed toward a solution of the basic emotional difficulties underlying the defect. These are often very difficult to get at and require a type of detailed clinical investigation which the teacher cannot be expected to undertake.

In dealing with mild or early cases of stuttering, however, teachers have an important contribution to make. They can do this most effectively by paying less attention to the speech of the stutterer and more attention to his emotional condition while trying to speak. Whatever puts him at his ease, assists his speech. Whatever adds to his emotional distress, impedes his speech.

The importance of this factor is illustrated by one of the treatment methods sometimes used in difficult cases. This is the method of encouraging the subject to practise deliberate voluntary stuttering. The main value of this method seems to be

that it tends to relieve emotional pressure. The very suggestion that he should deliberately try to stutter comes as a surprise to the child who has been led to suppose that there is something disgraceful about his stuttering.

There is some reason to believe that one of the indirect sources of emotional tension responsible for stuttering in some cases is the forced use of the right hand in a dominantly left-handed child. If the shift from left to right-handedness can be accomplished quietly and smoothly without conflict or forcing, it may cause no trouble. But whenever the left-handed inclination is strong and persistent, we are wise not to interfere with forcing methods which result in emotional strain and may cost the child more than it is worth to be right-handed.

XIII

THE ROLE OF THE TEACHER

IN preceding sections, consideration has been given to certain of the mental health problems to be found among normal children in school. It should be apparent from the discussion of these problems that teachers play a very important role in respect to the mental health of their pupils. It may be noticed that this role includes both the intelligent *treatment* of mild mental health difficulties and also the *prevention* of such difficulties through the deliberate avoidance of those methods and attitudes which may give rise to them.

Treatment

Our purpose in discussing certain "symptoms" of poor mental health has been to illustrate an approach to these problems by which teachers can make a constructive contribution toward better mental health in school. This approach is neither abstruse nor complicated. It calls for no great technical knowledge or special skill. Described briefly, it requires merely the consistent application of a single general principle: "*Look for causes before treating symptoms.*"

When we ask a physician what we should do about a headache or a fever, we know that he will start in by trying to find out what is responsible for our symptoms. But when we ask ourselves

what we should do about Johnny's temper tantrums or Mary's "sick headaches," we often forget that we should start in the same way—by trying to find out what is causing them. There is only one proper answer to the question "What should I do?" and that is: "Try to *understand* before you *do* anything."

Any impatience to start "doing something" about the symptoms of poor mental health in children is a serious mistake. Attempts to deal directly with these symptoms not only fail to remove them but usually add to their severity. Until we have gained at least some partial insight into the causal factors responsible for the difficulty, our active interference is likely to do more harm than good.

Prevention

The early and intelligent treatment of mental health problems is an important aspect of the teacher's responsibility. Another aspect, however, is the prevention of any of these problems which might result from our methods or attitudes in the classroom. Those who have made a special study of this question consider that the two most serious school-room hazards to the mental and emotional health of children are regimentation and an emphasis on competition.

Regimentation is the outstanding characteristic of that classroom in which one hears the teacher

say "Now children sit up straight, feet flat on the floor, hands behind the back, eyes front, no noise." In such a room, of course, everything is very neat and orderly. There is no whispering, no noise, and little or no movement. The teacher has complete control and holds the centre of the stage. The pupils behave like good little soldiers—quiet, obedient, cowed, and passive—while the sergeant-major gives commands.

This picture is rather overdrawn. Actually there are few classrooms in which such perfect regimentation is achieved. Fortunately, there are too many children who are so normal and healthy that they refuse to submit to such a programme. Unfortunately, however, there are still some teachers who imagine that strict regimentation is a desirable objective, that it is evidence of "good discipline." The fact is that a thoroughly regimented class is evidence of nothing but poor mental health on the part of the pupils and lack of ability on the part of the teacher. It is only when teachers have failed at the task of teaching that they are satisfied to become drill-masters. Pride in one's "iron discipline" is, after all, a poor substitute for the fun of being a good teacher.

Constant emphasis on speed competitions in the classroom produces an atmosphere of emotional tension which ultimately is detrimental to both physical and mental health. Individual

differences in ability make such competitions not only unfair but futile. They have, in the past, led to an emphasis on school standing, marks, grades, etc., which has certainly been one of the most unhealthy characteristics of our whole educational system from kindergarten to university. Parents, of course, are often worse offenders than teachers in stressing the competitive aspects of school activities. But we, as teachers, cannot escape our responsibility to help rid the community of the absurd notion that high standing in school work and rapid academic progress are the most important things in a child's life.

The role of the teacher in contributing to the better mental health of children in school is not adequately indicated by referring to the early treatment of mental health problems and the avoidance of those methods of teaching which tend to produce such problems. If we want children to develop into cheerful, well-poised, unprejudiced, vigorous, healthy adults, then it is essential that those who are responsible for their training should possess these same characteristics. Accordingly, we now turn to a consideration of what is without doubt the most important single factor in producing sound mental health in pupils—the personal mental health of the teacher.

XIV

THE HEALTH OF THE TEACHER

THERE are several important reasons why teachers should take an intelligent interest in the preservation of their own personal health. In the first place, teachers, like other people, find that any degree of wholesome satisfaction in living depends directly on the maintenance of reasonably good health. And teachers, even more than other people, need to learn how to preserve their own health.

This is not because the profession of teaching presents any special hazards to health. On the contrary, there is ample evidence that teaching is, in most respects, conducive to good health. Compared to other professional groups, teachers have relatively low mortality rates and a somewhat longer life expectancy. They also show relatively low rates for severe illnesses of a serious character. In general, it appears that persons who enter the teaching profession have about as much good health as they would have enjoyed if they had chosen some other vocation.

On the other hand, minor illnesses of a preventable nature are found to occur among teachers with disproportionate frequency. Colds, indigestion, and so-called "nervousness" account for the bulk of absence and incapacitation on the part of teachers. This suggests that much of the poor

health found among teachers results either from carelessness or from an inadequate understanding of how to protect their own physical, mental, and emotional health. Certainly, teachers would seem to have very sound personal reasons for giving intelligent attention to this problem.

However, the teacher's personal health is not just the teacher's own private affair. In our modern world the preservation of health has become an important social obligation. It is obvious that anyone with typhoid fever or diphtheria cannot be permitted to regard his illness as a matter of purely private concern. Yet the possibility of spreading such directly communicable diseases is not the only way in which a person may have a harmful effect on the health of the community in which he lives. A person's health depends to a large extent on certain habits of living. These habits, whether good or bad, are apt to spread in any group in which they are practised. Thus the health of the individual has important social implications.

In the case of teachers, these social implications are particularly clear. The personal health of teachers is a matter of direct importance to the health of their pupils. This is not just a speculative opinion. In several recent studies, it has been demonstrated that healthy teachers have an observably favourable influence on the health of

their pupils. In one of these studies,[1] for example, the mental health of 73 fifth and sixth grade teachers was surveyed and a similar survey made of the mental health of their 1,095 pupils. It was found that the pupils of teachers in good mental health showed measurably greater mental and emotional stability than did the pupils of teachers in poor mental health. Where pupils have been studied over a period of years as they passed from teacher to teacher in a graded school, the records show in graphic fashion the extent to which the health of the class as a whole tends to improve or deteriorate depending on the health of the teacher concerned.

There are, then, both personal and social reasons why teachers need to preserve their own personal health. But there are, in addition, strictly professional reasons. The truth is that a teacher's success *as a teacher* is largely dependent on health. This is because it is quite impossible to be both a good teacher and a sick teacher at the same time. Any teachers who fondly imagine that they are nobly sacrificing their own personal health in the interests of their pupils are sadly misled. It can never be, under any circumstances, in the best interests of pupils to be taught by a person in

[1]P. L. Boynton, H. Dugger, and M. Turner, "The Emotional Stability of Teachers and Pupils (*Journal of Juvenile Research*, 1934, XVIII, 223-32).

poor health. "Devotion to duty" may sound like a plausible excuse but it is never an adequate justification for being sick.

In this connection it is important to realize that the mental and emotional aspects of health are no less significant in determining the professional success of a teacher than are the physical aspects of health. In a comprehensive survey of the health records and the teaching efficiency of 5,150 teachers, the results led the investigators to conclude, in part, as follows: ". . . personality maladjustments are responsible for failure in teaching more often than physical disorders. This emphasizes the importance of good health in the broadest sense of that term. The presence of intense and persistent worries also stands out as a health hazard of the first magnitude."[2]

It is evident that teachers need to maintain a high level of sound personal health if they are to gain personal satisfaction in living, if they are to be desirable members of the society in which they live, and if they are to be good teachers. In the discussion which follows, attention is drawn to certain of the general principles underlying robust mental and emotional health which are of particular importance for teachers.

Careful study of the mentally ill has indicated

[2] "Fit to Teach" (*Ninth Yearbook*, Department of Classroom Teachers, National Educational Association, U.S.A., 1938, p. 39).

that much mental illness is as unnecessary as the decay of healthy teeth through failure to care for them properly. Not only can the mental health of children be improved by the intelligent treatment of unhealthy tendencies, but much can be done to preserve and improve our own mental health by giving attention to a few simple principles of healthy living.

There is nothing abstruse or mysterious about these principles. There is no need to be a psychiatrist or a psychologist in order to understand them. We do not need to be physicians in order to understand something about how to preserve good physical health. We are all familiar with the simple but important habits which we must practise if we are to enjoy a reasonable degree of good physical health. Although less commonly recognized, it happens that there are equally simple and equally important habits which we must develop if we are to enjoy good mental and emotional health.

In discussing certain of these habits, an effort will be made to give teachers an opportunity to evaluate the degree of their own mental and emotional health. Mental health, like physical health, is always a matter of degree. No one is ever in perfect health. Careful medical examination will always reveal room for improvement in our physical condition. Similarly, honest self-examina-

tion will always reveal room for improvement in our mental and emotional condition. Furthermore, our health is never static. It is not a state that we can achieve, and thereafter sit back and admire. It is rather an objective toward which we must keep working as long as we live.

Thus, an intelligent study of our own mental health will always indicate certain weaknesses. There should be nothing surprising or alarming about such a discovery. However, there are certain things that the intelligent person will do about such weaknesses when they are recognized.

The first step is to look for the cause. This may not be as simple as it sounds. Our inclination is to look for the cause in conditions which are not under our control, to point sadly to the frightful hardships of a teacher's existence or to our personal misfortune or to our supposedly inherited "nervous" disposition. Such evasions relieve us of responsibility. There is nothing that *we* can do about the problem. Whenever we arrive at this conclusion, we may be sure that our thinking has become twisted and that it is time to start looking in a more straightforward fashion for the real cause of the difficulty. Often we can be helped to do this by a friend whose maturity and sound practical judgment we have learned to respect. Occasionally, we may need the help of someone

who has had special training in dealing with such problems.

Having determined the cause of the weakness, it will be found that there are very definite things we *can* do about it. The most important factors determining our mental health are factors which are largely under our own control. Hence, the next step is to set about reorganizing our programme of living in such a way as to remove the cause, and substitute healthy for unhealthy habits of adjustment.

In trying to evaluate the degree of their own mental health, teachers are wise to give special consideration to such factors as the following:

1. Physical Health

How efficient is my body? Does it function smoothly and satisfactorily? Does it help me or hinder me in the work I try to do? When something goes wrong with my body, what do I do about it? When it is healthy, do I do those things I know are necessary to keep it healthy? Honest and thoughtful answers to questions such as these provide a useful starting-point in a survey of personal mental health. A healthy body constitutes an essential foundation for good mental and emotional health.

If teachers are not noted for their good physical health, this is not usually because they fail to be

concerned about it. Indeed, there seem to be few things about which teachers worry more than about their physical health. However, the maintenance of physical health does not depend on the amount of anxious concern we show over it. It does depend on the extent to which we take intelligent action to preserve it.

Worrying about our health is actually a form of self-indulgence which serves as a substitute for *doing* anything about the source of the worry. Instead of taking active steps to remove the causes of our poor health, we often prefer to go about discussing the subject at great length with our friends and associates. In this way, we may find it possible to extract a great deal more sympathy and attention than we would otherwise receive. That there is some satisfaction to be gained from acting like a martyr to one's own poor health cannot be denied. That it is a definitely unhealthy habit should be clearly recognized.

The smooth and efficient functioning of a motor car is a far less delicate matter than the smooth and efficient functioning of a human body. When something goes wrong with his car, the average driver today is wise enough to secure expert advice before starting to tinker with the mechanism himself. Yet, when something goes wrong with their bodies many people show no hesitation whatever in tinkering ignorantly with

self-prescribed "remedies" and patented "cure-alls" before consulting a competent physician. In this way, minor health problems are often unnecessarily exaggerated and the problem of intelligent treatment is made much more difficult.

The habit of securing competent advice as soon as there are any indications of poor health is one of the first and most important habits to develop in the interests of both physical and mental health. Incidentally, the habit of *doing* something about these problems when they arise (and doing it promptly), has been found to be the best antidote to the unhealthy habit of *worrying* about it.

The nature of the illnesses to which teachers are particularly susceptible suggests that teachers would be well-advised to undertake the actual practice of those simple habits upon which good physical health is known to be based. Nearly everyone knows that it is desirable to develop regular habits in respect to personal hygiene, sleeping, eating, elimination, etc. Yet the actual practice of such habits is not nearly as widespread as might be supposed. Certainly, it is evident that many teachers fail to organize for themselves a programme of living which will provide food, rest, and exercise in such amounts and of such a type as to maintain an efficiently functioning body.[3]

[3]For example, in a survey of the actual health practices of 600 teachers, it was found that more than half of the group had made

Although such habits appear to be related primarily to physical health, it happens that they also constitute an essential foundation for good mental and emotional health.

2. The Enjoyment of Living

Am I a happy person? Am I glad to be alive? Have I learned how to get real satisfaction out of living? Do I enjoy my work?

It might be argued that these are rather trivial questions, quite beneath the dignity of a serious-minded teacher, and that there are more important things for a teacher to do than "have fun." Be that as it may, the fact remains that the most striking characteristic of people who are in good mental and emotional health is that they are happy people. Persistent unhappiness is a symptom of poor mental health. It is an indication that there are difficulties in adjustment which are not being solved.

Happiness, of course, is nothing more than a symptom, a by-product of healthy living. To make it an end in itself, to regard it as an objective, is a fairly sure way of losing it. To make a pretence at happiness in some twisted Pollyanna fashion, is neither very mature nor very healthy. To recognize unhappiness when it exists, to search out the cause

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no adequate provision for physical exercise (F. R. Hicks, *The Mental Health of Teachers*, Peabody Contributions to Education, 1934, no. 123).

of that unhappiness, and to do something constructive about removing it,—such is the procedure of healthy people.

But can the causes of unhappiness always be removed? Is it not sometimes quite impossible to be happy? It is certainly true that many of the causes of unhappiness are not under our control. It is also true that a person who is *always* happy may not be very healthy. It is inevitable that many things will make the healthy person unhappy—for a time. It is both normal and healthy for the teacher who has been baited by pupils or severely criticized by an inspector to be unhappy. It is natural for the young man jilted in love to be unhappy. (Indeed, it is not very flattering unless he is.) But it is not healthy for him to wear a broken heart on his sleeve for years because of this tragedy. Persistent or chronic unhappiness is neither inevitable nor healthy. When unduly prolonged, it becomes a symptom of poor adjustment and calls for intelligent action in locating and removing the cause.

3. Breadth of Outlook

Am I human? Am I *really* a human being? Or am I just a teacher? Do I dress like a teacher, act like a teacher, talk like a teacher, think like a teacher, and even eat like a teacher? Am I a teacher all of the time or do I give myself a change

of atmosphere. Is my mental outlook limited to the four walls of the classroom or have I a broader horizon that gives me a chance to see the classroom and its contents in healthy perspective?

There is probably no greater hazard to the mental health of teachers than downright narrow-mindedness. There are several reasons for this. On the one hand, as teachers, they are expected by the community to be perfect models of deportment and, by their example, to inculcate in their pupils whatever notions of "correctness" may happen to be prevalent in that particular community. On the other hand, as teachers, they are apt to be regarded by the community, and especially by their pupils, as the final authority on intellectual matters. Because of the dominant and authoritative position which many teachers feel they must assume in the classroom, there is special danger of losing a proper sense of perspective. This is sometimes reflected by the excessive attention paid to minor classroom virtues, the rigid maintenance of petty standards of deportment, and the tendency to become "righteously indignant" if anyone dares to question them.

Of course, no one believes he is narrow-minded. The illusion of broad-mindedness is well-nigh universal. Yet we all show a very strong tendency to elevate our own local customs and taboos to the level of universal laws and regard them, thereafter,

as final and absolute. In this position we may feel very virtuous and superior but it is really a position based on ignorance and fortified by cowardice. People who have had an opportunity to travel widely find it very difficult to remain rigid and narrow in their outlook. They discover that, beyond the boundaries of their own immediate locality, people have other standards, other views, other values, and other ways of living.

If teachers cannot travel widely, they can at least make sure that their mental outlook is not limited completely by the four walls of a classroom. If they cannot explore the world, they can at least explore their neighbourhood. If they have to be teachers most of the time, they can at least afford the luxury of being ordinary human beings some of the time. In the interests of their own mental health, it is of the utmost importance that teachers should spend as much of their free time as possible in the society of people whose sense of values has not been determined (one might almost say, warped) by a purely academic background. And no teachers need this more than those who have become so swamped by petty school routine—by tests, drills, reviews, detentions, records, and reports—that they *have* no "free" time. It is important to teachers that they give themselves a chance, now and then, to breathe fresh mental air. It need hardly be said that it is important to

pupils that they should be taught by people who are tolerant, sensible human beings as well as efficient pedagogues.

4. Living in the Present

Do I spend much of my time gloating over past successes or regretting ancient failures? Do I spend much of my time planning dreamily for the future? Have I developed the habit of living in the "here" and "now"? Have I learned how to live in "day-tight compartments"?[4]

We know that if a person tried to drive a motor car in city traffic with his eyes glued to the rear-vision mirror, he would soon get into difficulties. Yet there are people who try to get through life with their attention fixed on past exploits, past tragedies, events which happened long ago. They have little time left to see where they are going or what they are doing right now. No one with a worthwhile task to perform can do it properly if he is constantly looking back over his own shoulder.

We know, too, that a person would not get very far if he tried to drive a car through city traffic with a pair of binoculars strapped to his head which showed him the street conditions ten blocks away. Yet there are people (and even some teachers) who spend most of their time thinking

[4]Sir William Osler, *A Way of Life* (Constable, 1928).

about tomorrow, or next week, or next year. They are so concerned about what they are *going to do* that they have little time to pay attention to what they *are doing now.*

An occasional glance at the past and some planning for the future are both necessary. However, the mentally healthy person is one who has learned how to insulate himself to a large extent against both past and future in order that he can give the major portion of his attention and energy to the present.

5. Making Prompt Decisions

Do I suffer from chronic indecision? Do I often hang suspended in prolonged dilemmas? Have I deliberately trained myself to make up my mind promptly or have I slipped into the habit of fussing interminably over trivial decisions?

Being decisive is a habit. Furthermore, it is a very desirable habit from the point of view of mental health. Chronic indecision is not only inefficient; it is also highly distressing. Contrary to what we often teach children, prolonged and laborious deliberation over what we are going to do seldom contributes very much to the correctness of a decision. There are relatively few of the decisions which we commonly have to make, in which mistakes cannot be repaired. Excessive caution

is not so much an indication of wisdom as it is an evidence of unwarranted fear of failing.

Indecision, hesitancy, and vacillation in front of a class reveal an inadequacy in the teacher of which pupils are quick to take advantage. In deliberately developing the habit of dealing with issues in a confident and decisive manner, the teacher must, however, avoid the opposite danger of becoming dogmatic and domineering. Even teachers must be prepared to admit the possibility of occasional mistakes. Teachers who insist on being infallible cannot really afford to be decisive.

6. Getting Along With People

How do I get along with other people? How do I get along with the people in my community? With the parents of my pupils? With my superior officers? With my fellow teachers? With my own pupils? Do I like people? Do they like me?

The ultimate measure of our mental health is the ease and smoothness with which we get along with other people. But this is one of the most difficult of all questions on which to keep our thinking straight. Whenever we find that we have failed to get along well with a person or a group of people, we immediately bristle with excuses, evasions, and alibis. We are always full of "explanations" which neatly place the blame for any difficulties on others,—never on ourselves.

The ability to get along well with people is not, as commonly supposed, a characteristic with which some persons are born and which others naturally lack. It is a skill or habit which some acquire early but which others must deliberately develop. Learning how to get along well with other people is a task which deserves much more serious study and consideration than it usually receives. Learning to get along with people means learning to like them; learning to like them means learning to understand them; learning to understand them means, among other things, learning to listen to them. It is interesting that, in dealing with our pupils, many of us talk so much and listen so little, that we scarcely get to know them, let alone like them.

However, it is certainly not the intention at this point, to launch into a discussion of "How to Become a Social Success" (in six "easy" lessons!). In the first place, the writer does not believe that the task of getting along well with people is as easy a matter as some of the advertisements would seem to suggest. In the second place, it will be much easier (and possibly just as useful) to conclude this discussion by indicating briefly certain ways in which teachers can easily become highly unpopular.

For teachers, the problem of how to win friends and influence people is vastly more difficult than

the problem of how to *lose* friends and *infuriate* people. It may be that there is something about a teacher's training and a teacher's work which makes it comparatively easy to become unpopular. At any rate, there are several convenient methods by which teachers can make their pupils, their colleagues, and everyone else dislike them intensely.

One method which seldom fails to achieve this result is to assume the role of a martyr. To get the best effect, of course, one needs to be a *groaning* martyr. It is not enough, for example, to realize that you are very much over-worked and grossly underpaid; the important thing is to be sure that everyone *else* realizes it. Dwell on the peculiar difficulties in your particular work. Talk about the unparalleled incorrigibility of your problem pupils. Make it clear that the constant pressure of your responsibilities and the intolerable "nerve-wracking" strain of teaching have driven you almost to the brink of distraction. Convey the impression that, despite your heroic fortitude, you are likely to collapse at any moment. Never fail to discuss at length any aches and pains which can be used to add to your song of complaint. In short, parade your sufferings so constantly before your pupils, your colleagues, and your friends that you simply throttle the sympathy out of them.

Another way for teachers to become disliked,

which is quite different but only slightly less effective, is for them to make a special point of their dignity. Be *very* dignified. Never forget for a single moment that you are a teacher and that, as such, you have an important position to maintain. Maintain it with all your might. Insist that, on all occasions, you are accorded all of the respect which is due your position (and more, if possible). If you condescend to unbend at all, be sure that you do it in such a patronizing fashion that no one will dare to take advantage of your apparent friendliness and mistake you for an ordinary human being.

There are, of course, several other methods of achieving unpopularity, but these two are so reliable and convenient for teachers to use that it will be unnecessary to amplify the subject further. Perhaps it should be said, however, that taking the trouble to learn how to get along with people and be well liked by them not only makes for better mental health but results in better and more effective teaching.

FURTHER READING

Many teachers have found that they can achieve a better and quicker understanding of the mental health problems presented by children in school when they have studied the findings and observations of those who have made a special study of this aspect of child development. Such findings are now available to teachers in useful and readable form. The list of books which follows represents only a preliminary selection of titles from a body of literature which has now become very extensive. It may serve, however, as a worthwhile beginning for those teachers who have the necessary requirements. These requirements are briefly: *sufficient ability to read seriously; sufficient sense to read critically; and sufficient intellectual curiosity to read widely.*

1. Mental Health of the Teacher

Anderson, C. M.—*Emotional Hygiene: The Art of Understanding.* Lippincott 1937.

Bowman, K. M.—*Toward Peace of Mind: Everyday Problems in Mental Health.* Allen and Unwin 1936.

Burnham, W.—*The Wholesome Personality.* Appleton 1932.

Chant, S. N. F.—*Mental Training: A Practical Psychology.* Macmillan 1934.

Jacobson, E.—*You Must Relax.* Whittlesey House 1934.

Jastrow, J.—*Keeping Mentally Fit.* Greenberg 1928.

Morgan, J. J. B.—*Keeping a Sound Mind.* Macmillan 1934.

Osler, Wm.—*A Way of Life.* Constable 1928.

Simon, H. W.—*Preface to Teaching.* Oxford University Press 1938.

Wright, M.—*Getting Along with People.* McGraw-Hill 1935.

2. Mental Health of Pupils

Averill, L. A.—*The Hygiene of Instruction.* Houghton Mifflin 1928.

James, Wm.—*Talks to Teachers on Psychology.* Holt 1900.

Morgan, J. J. B.—*Psychology of the Unadjusted School Child.* Macmillan 1924 (revised 1936).

Pressey, S. L.—*Psychology and the New Education.* Harper 1933.

Rivlin, H. N.—*Educating for Adjustment: The Classroom Applications of Mental Hygiene.* Appleton-Century 1936.

Ryan, W. C.—*Mental Health Through Education.* Commonwealth Fund 1938.

Sherman, M.—*Mental Hygiene in Education.* Longmans, Green 1934.

Symonds, P. M.—*Mental Hygiene of the School Child.* Macmillan 1934.

3. Mental Hygiene

Beers, C. W.—*A Mind that Found Itself.* Doubleday, Doran 1907 (revised 1925).

Deutsch, A.—*The Mentally Ill in America: A History of Their Care and Treatment from Colonial Times.* Doubleday, Doran 1937.

Groves, E. R. and Blanchard, P.—*Introduction to Mental Hygiene.* Holt 1930.

Kirkpatrick, E. A.—*Mental Hygiene for Effective Living.* Appleton-Century 1934.

Landis, C. and Page, J. D.—*Modern Society and Mental Disease.* Farrar and Rinehart 1938.

Seabrook, W. B.—*Asylum.* Harcourt 1936.

Shaffer, L. F.—*The Psychology of Adjustment.* Houghton Mifflin 1936.

Wallin, J. E. W.—*Personality Maladjustments and Mental Hygiene.* McGraw-Hill 1935.